

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10259

10299

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A</u>		d. STREET ADDRESS <u>4803 WELLINGTON DR.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK RAPHAEL ACOSTA</u>		4. DATE OF DEATH <u>SEPT. 23</u> 19 <u>58</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/28/23</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>25</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
13. BIRTHPLACE (State or foreign country) <u>Canal Zone</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>Frank R. Acosta</u>		16. MOTHER'S MAIDEN NAME <u>Alice V. Acosta</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>Yes Navy WW 2</u>		18. SOCIAL SECURITY NO. <u>None</u>	
19. INFORMANT <u>Alice V. Acosta-mother-same as 2d</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Occlusion</u> (a), stating the underlying cause last. DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aspiration of gastric contents</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE OF DEATH (If primary or contributing cause of death) <u>Aspiration</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>R/23/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>SEP 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text, possibly "JOHN J. SMITH"]
2. AGE: [Faint text, possibly "45"]
3. SEX: [Faint text, possibly "Male"]
4. OCCUPATION: [Faint text, possibly "Carpenter"]
5. PLACE OF BIRTH: [Faint text, possibly "Boston, Mass."] ☐ Foreign ☐ Native
6. DATE OF DEATH: [Faint text, possibly "Jan 15, 1912"]
7. TIME OF DEATH: [Faint text, possibly "10:30 AM"]
8. PLACE OF DEATH: [Faint text, possibly "Home"]
9. CAUSE OF DEATH: [Faint text, possibly "Myocardial Infarction"]
10. MANNER OF DEATH: [Faint text, possibly "Natural"]
11. SIGNATURE OF EXAMINER: [Faint signature]
12. SIGNATURE OF ATTENDING PHYSICIAN: [Faint signature]
13. SIGNATURE OF CORONER: [Faint signature]
14. SIGNATURE OF JURY: [Faint signature]
15. SIGNATURE OF WITNESSES: [Faint signature]
16. SIGNATURE OF DECEASED: [Faint signature]
17. SIGNATURE OF NEXT OF KIN: [Faint signature]
18. SIGNATURE OF CLERGYMAN: [Faint signature]
19. SIGNATURE OF MINISTER: [Faint signature]
20. SIGNATURE OF CHURCH WARDEN: [Faint signature]
21. SIGNATURE OF BURIAL PLACE: [Faint signature]
22. SIGNATURE OF FUNERAL HOME: [Faint signature]
23. SIGNATURE OF CEMETERY: [Faint signature]
24. SIGNATURE OF INTERMENT: [Faint signature]
25. SIGNATURE OF CREMATION: [Faint signature]
26. SIGNATURE OF OTHER: [Faint signature]

10300

CERTIFICATE OF DEATH

Reg. Dist. No.

10260

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admision) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 11½ yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,405 LORAIN AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle JOHN Last ADAMSON		4. DATE OF DEATH Month SEPT. Day 22 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/21
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Contractor		10b. KIND OF BUSINESS OR INDUSTRY (self-employed)	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD E. ADAMSON		14. MOTHER'S MAIDEN NAME MINNIE KRUTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW # 2		16. SOCIAL SECURITY NO. 578-18-1916	
17. INFORMANT Mrs. Elizabeth R. Adamson, 10,405 Lorain Ave. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma, right kidney 180x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 19 58 , to Sept 19 58 , that I last saw the deceased alive on Sept 21 19 58 , and that death occurred at 12 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard A. Fitzgerald		ADDRESS (Street, city or town, state) 217 University Blvd E. AS	
DATE SIGNED 9-22-58			
PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/25/58	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR SEP 24 58		DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Kinn			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10301

CERTIFICATE OF DEATH

Reg. Dist. No.

10261

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Herbert Nolan Adamson		4. DATE OF DEATH Month Day Year September 10 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert L. Adamson		14. MOTHER'S MAIDEN NAME Helen Adamson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Robert L. Adamson, Rockville, Md.	
17. INFORMANT Robert L. Adamson, Rockville, Md.		Address 5100 Muncaster	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO Advanced Sen. Arteriosclerosis (c) 209.1		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 Sept 1958 , to 10 Sept 1958 , that I last saw the deceased alive on 9 Sept 1958 , and that death occurred at 6:50 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) OLNEY, MD	
ACTUAL SIGNATURE John B. Zeigler		DATE SIGNED 10 Sept 58	
PHYSICIAN'S NAME (Type) John B. Zeigler			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-58	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		24a. RECEIVED BY REGISTRAR SEP 19 58	
24b. REGISTRAR'S SIGNATURE Ernest C. Gartner			

CERTIFICATE OF DEATH

1931

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1886		Maryland		Baltimore		Heart Disease		Jan 15, 1931		10:00 AM		Home		J. A. Smith		W. B. Jones	
Occupation		Married		Single		Widowed		Divorced		Color		Race		Religion		Education		Previous Illness		Previous Injuries		Previous Operations	
Teacher		Yes		No		No		No		White		Caucasian		Roman Catholic		High School		None		None		None	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
Jan 15, 1931		10:00 AM		Home		J. A. Smith		W. B. Jones		Jan 15, 1931		10:00 AM		Home		J. A. Smith		W. B. Jones		Jan 15, 1931		10:00 AM	

RECORD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G234 9/24/58 gsj

10262

10302

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 62 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS (no street address)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle D.(initial only) Last Allen				4. DATE OF DEATH Month September Day 16 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 25, 1888	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William Allen				14. MOTHER'S MAIDEN NAME Matilda Swicegood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 237X Metastatic Brain Tumor (confirmed by biopsy) 13 yrs. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable primary neoplasm of lung or kidney (unconfirmed) ? DUE TO (c) ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 16, 19 58 , to September 16, 19 58 , that I last saw the deceased alive on September 16, 19 58 , and that death occurred at 5:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/16/58 ACTUAL SIGNATURE William R. Lewis M.D. National Institutes of Health PHYSICIAN'S NAME (Type) William R. Lewis, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21-58		22c. NAME OF CEMETERY OR CREMATORY Robbinson Cemetery		22d. LOCATION (City, town, or county) (State) Weaubleau MO.	
23. FUNERAL DIRECTOR'S SIGNATURE Real Funeral Home ADDRESS 4812 GA Avenue				24a. REC'D BY REGISTRAR SEP 17 '58		24b. REGISTRAR'S SIGNATURE Carlton S. Thoms	

1

10303

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
c. LENGTH OF STAY IN 1b 41 days				d. STREET ADDRESS 5051 Bradley Boulevard			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ralph Middle David Last Anderson				4. DATE OF DEATH Month September Day 10 Year 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 11, 1917	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 10 Days 29		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fabrication Inspector				10b. KIND OF BUSINESS OR INDUSTRY Fabricating		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Grover Anderson				14. MOTHER'S MAIDEN NAME Lizzie Connine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 260-16-8045		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 286.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nontropical Sprue DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 13 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia, 24 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 31, 1958 , to September 10, 1958 , that I lost saw the deceased alive on September 10, 1958 , and that death occurred at 11:40 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/10/58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Dr. G. O. Barnett M.D.							
PHYSICIAN'S NAME (Type) DR. G.O. BARNETT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 9/11/58		22c. NAME OF CEMETERY OR CREMATORY Jeffersonville Cem.		22d. LOCATION (City, town, or county) (State) Jeffersonville, Ga.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 15 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hays			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNCLASSIFIED STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18

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10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
 10304
 CERTIFICATE OF DEATH

10264

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>403 Joseph Street</u>		d. STREET ADDRESS <u>403 Joseph Street</u>	
3. NAME OF DECEASED (Type or print) First <u>THEODORE</u> Middle <u>WILLIAM</u> Last <u>ARMIGER</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25 1907</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bulldozer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Operator</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-16-2398</u>	
17. INFORMANT <u>Alice V. Armiger-wife-same as 2d</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLISM</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATELECTASIC - LEFT CHEST</u> DUE TO (c) <u>BRACHIOGENIC CARCINOMA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> <u>2 MONTHS</u> <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 29, 1958</u> , to <u>SEPT 16, 1958</u> , that I last saw the deceased alive on <u>14 SEPT, 1958</u> , and that death occurred at <u>8:30 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon S. Rosenberger</u> M.D.		ADDRESS (Street, city or town, state) <u>26 W SUMMIT AVE</u> DATE SIGNED <u>16 SEPT 1958</u>	
PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger</u>		<u>GAITHERSBURG, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

VS AIS (4)
ISM 9/55

10306

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4881 Battery Lane		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4881 Battery Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARENCE CLIFFORD ATWELL First Middle Last		4. DATE OF DEATH September 28, 1958 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2 1873 yrs. 85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Manager		10b. KIND OF BUSINESS OR INDUSTRY Ohio Audit Bureau	11. BIRTHPLACE (State or foreign country) Ohio
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 275-01-0189	
17. INFORMANT Mrs. Harriet Blackstone-same as 2d Address Daughter		12. CITIZEN OF WHAT COUNTRY? USA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arterio sclerosis DUE TO (c) years. INTERVAL BETWEEN ONSET AND DEATH Immed		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/20 , 19 56 , to 9/28 , 19 58 , that I last saw the deceased alive on 8/22 , 19 58 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Zanesville, Ohio DATE SIGNED 9/29/58 ACTUAL SIGNATURE Paul D. Cantor M.D. PHYSICIAN'S NAME (Type) Paul D. Cantor - 4709 Montgomery Lane, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	22b. DATE THEREOF 10/1/58	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Zanesville, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 30 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10267

10307

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>608 Dale Drive</u>				d. STREET ADDRESS <u>1608 Dale Drive</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Valorous Gage Austin</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1903</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Private Detective.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Credit Investigator</u>		11. BIRTHPLACE (State or foreign country) <u>Washington</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Valorous G. Austin</u>				14. MOTHER'S MAIDEN NAME <u>Blanche I. Boss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-34-8016</u>			
17. INFORMANT <u>Mae C. Austin</u> wife Address <u>608 Dale Dr. S.S. Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446x</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> (c) <u>1 year</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>advanced cerebral arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 15</u> , 1957, to <u>Sept 5</u> , 1958, that I last saw the deceased alive on <u>Sept 4</u> , 1958, and that death occurred at <u>6:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>DB Washington</u> M.D. <u>6234 Fa Ave NW Wash DC</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>9/5/58</u>			
PHYSICIAN'S NAME (Type) <u>Daniel B. Washington M.D. 6234 Fa Ave NW Wash DC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>SEP 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

10308

CERTIFICATE OF DEATH

Reg. Disf. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 11 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital				e. STREET ADDRESS 4525 Windsor Lane			
3. NAME OF DECEASED (Type or print) First Charles Middle Joseph Last Ayers				4. DATE OF DEATH Month Sept. Day 26 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/6/82	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 11 Days 20 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Yard		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Ayers				14. MOTHER'S MAIDEN NAME Mary S. Ayers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles J. Ayers Jr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis & myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 12 hours 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) g-26		(County) (State)	
21. I certify that I attended the deceased from 8 AM - 9:26 , 19 58 , to 12:45 PM , 19 58 , that I last saw the deceased alive on 9-26 , 19 58 , and that death occurred at 12:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip P. James				ADDRESS (Street, city or town, state) M.D. Washington Clinic, D.C.			
DATE SIGNED SEP 30 '58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. REC'D BY REGISTRAR Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10008

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. DATE OF BIRTH May 19, 1928		4. PLACE OF BIRTH Jackson, Tennessee	
5. DATE OF DEATH April 4, 1968		6. PLACE OF DEATH Memphis, Tennessee	
7. TIME OF DEATH 2:01 PM		8. CAUSE OF DEATH Shot - Gun	
9. MANNER OF DEATH Homicide		10. MEDICAL HISTORY None	
11. OCCUPATION None		12. EDUCATION None	
13. RELIGION None		14. MARITAL STATUS Single	
15. SOCIAL SECURITY NUMBER None		16. SIGNATURE OF DECEASED None	
17. SIGNATURE OF WITNESS None		18. SIGNATURE OF PHYSICIAN None	
19. SIGNATURE OF CORONER None		20. SIGNATURE OF JURY None	
21. SIGNATURE OF STATE DEPARTMENT OF HEALTH None		22. SIGNATURE OF COUNTY DEPARTMENT OF HEALTH None	
23. SIGNATURE OF CITY DEPARTMENT OF HEALTH None		24. SIGNATURE OF DISTRICT DEPARTMENT OF HEALTH None	
25. SIGNATURE OF LOCAL DEPARTMENT OF HEALTH None		26. SIGNATURE OF NEAREST RELATIVE None	
27. SIGNATURE OF NEAREST RELATIVE None		28. SIGNATURE OF NEAREST RELATIVE None	
29. SIGNATURE OF NEAREST RELATIVE None		30. SIGNATURE OF NEAREST RELATIVE None	
31. SIGNATURE OF NEAREST RELATIVE None		32. SIGNATURE OF NEAREST RELATIVE None	
33. SIGNATURE OF NEAREST RELATIVE None		34. SIGNATURE OF NEAREST RELATIVE None	
35. SIGNATURE OF NEAREST RELATIVE None		36. SIGNATURE OF NEAREST RELATIVE None	
37. SIGNATURE OF NEAREST RELATIVE None		38. SIGNATURE OF NEAREST RELATIVE None	
39. SIGNATURE OF NEAREST RELATIVE None		40. SIGNATURE OF NEAREST RELATIVE None	
41. SIGNATURE OF NEAREST RELATIVE None		42. SIGNATURE OF NEAREST RELATIVE None	
43. SIGNATURE OF NEAREST RELATIVE None		44. SIGNATURE OF NEAREST RELATIVE None	
45. SIGNATURE OF NEAREST RELATIVE None		46. SIGNATURE OF NEAREST RELATIVE None	
47. SIGNATURE OF NEAREST RELATIVE None		48. SIGNATURE OF NEAREST RELATIVE None	
49. SIGNATURE OF NEAREST RELATIVE None		50. SIGNATURE OF NEAREST RELATIVE None	
51. SIGNATURE OF NEAREST RELATIVE None		52. SIGNATURE OF NEAREST RELATIVE None	
53. SIGNATURE OF NEAREST RELATIVE None		54. SIGNATURE OF NEAREST RELATIVE None	
55. SIGNATURE OF NEAREST RELATIVE None		56. SIGNATURE OF NEAREST RELATIVE None	
57. SIGNATURE OF NEAREST RELATIVE None		58. SIGNATURE OF NEAREST RELATIVE None	
59. SIGNATURE OF NEAREST RELATIVE None		60. SIGNATURE OF NEAREST RELATIVE None	
61. SIGNATURE OF NEAREST RELATIVE None		62. SIGNATURE OF NEAREST RELATIVE None	
63. SIGNATURE OF NEAREST RELATIVE None		64. SIGNATURE OF NEAREST RELATIVE None	
65. SIGNATURE OF NEAREST RELATIVE None		66. SIGNATURE OF NEAREST RELATIVE None	
67. SIGNATURE OF NEAREST RELATIVE None		68. SIGNATURE OF NEAREST RELATIVE None	
69. SIGNATURE OF NEAREST RELATIVE None		70. SIGNATURE OF NEAREST RELATIVE None	
71. SIGNATURE OF NEAREST RELATIVE None		72. SIGNATURE OF NEAREST RELATIVE None	
73. SIGNATURE OF NEAREST RELATIVE None		74. SIGNATURE OF NEAREST RELATIVE None	
75. SIGNATURE OF NEAREST RELATIVE None		76. SIGNATURE OF NEAREST RELATIVE None	
77. SIGNATURE OF NEAREST RELATIVE None		78. SIGNATURE OF NEAREST RELATIVE None	
79. SIGNATURE OF NEAREST RELATIVE None		80. SIGNATURE OF NEAREST RELATIVE None	
81. SIGNATURE OF NEAREST RELATIVE None		82. SIGNATURE OF NEAREST RELATIVE None	
83. SIGNATURE OF NEAREST RELATIVE None		84. SIGNATURE OF NEAREST RELATIVE None	
85. SIGNATURE OF NEAREST RELATIVE None		86. SIGNATURE OF NEAREST RELATIVE None	
87. SIGNATURE OF NEAREST RELATIVE None		88. SIGNATURE OF NEAREST RELATIVE None	
89. SIGNATURE OF NEAREST RELATIVE None		90. SIGNATURE OF NEAREST RELATIVE None	
91. SIGNATURE OF NEAREST RELATIVE None		92. SIGNATURE OF NEAREST RELATIVE None	
93. SIGNATURE OF NEAREST RELATIVE None		94. SIGNATURE OF NEAREST RELATIVE None	
95. SIGNATURE OF NEAREST RELATIVE None		96. SIGNATURE OF NEAREST RELATIVE None	
97. SIGNATURE OF NEAREST RELATIVE None		98. SIGNATURE OF NEAREST RELATIVE None	
99. SIGNATURE OF NEAREST RELATIVE None		100. SIGNATURE OF NEAREST RELATIVE None	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

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10309

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9, Film G-234 10/7/58 cac

Reg. Dist. No.

10269

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colisville-Beltsville Rd</u>		d. STREET ADDRESS <u>Colisville-Beltsville Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Leonard G. Bailey</u>		4. DATE OF DEATH <u>9-13</u> 19 <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1922</u> 9. AGE (In years last birthday) <u>36 3/4</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov.</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S C</u>	
13. FATHER'S NAME <u>Carl Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Frances Rice</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John T. Lancaster</u>		Address <u>Stur 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epileptic Seizures</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHECHT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-17-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swarden</u>		ADDRESS <u>Rockville, Md</u>	
24a. REC'D BY REGISTRAR <u>SEP 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10270

10310

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham			
f. STREET ADDRESS 6312 93rd Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Curtis Middle Warren Last BARNARD				4. DATE OF DEATH Month September Day 19 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 July 1934	
9. AGE (In years last birthday) yrs. 24		IF UNDER 1 YEAR Months 24 Days 24 Hours 24 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) South Dakota	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Donald W. BARNARD				14. MOTHER'S MAIDEN NAME Alyce Ruby BABB			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 9-3-52 to 8-23-56				16. SOCIAL SECURITY NO. (Wife) Mrs. Nancy L. BARNARD (Same As #2)			
17. INFORMANT (Wife) Mrs. Nancy L. BARNARD (Same As #2)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 201X DUE TO (c) 2 yrs INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11 Sept. 19 58 to 19 Sept. 19 58 , that I last saw the deceased alive on 19 Sept. 19 58 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED ACTUAL SIGNATURE August Miale Jr. M.D. U.S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) AUGUST MIALE, JR. LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 5801 Cleveland Ave., Riverdale, Md. ADDRESS 17-391				24a. REC'D BY REGISTRAR SEP 23 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

MEDICAL CERTIFICATION

2

51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10271

10311

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1915 Locust Grove Rd.</u>			d. STREET ADDRESS <u>1915 Locust Grove Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William Augustus Barr</u>			4. DATE OF DEATH <u>Sept 6 1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-1900</u>		9. AGE (In years last birthday) <u>58</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.O. Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Wm Barr</u>		
14. MOTHER'S MAIDEN NAME <u>Julia Lynch</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u></u>			17. INFORMANT <u>Ella Barr (wife)</u> <u>Stem 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>		20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-6-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>	
22d. LOCATION (City, town, or county) <u>Washington DC</u>		22e. (State) <u></u>		22f. (Country) <u></u>	
23. BURIAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		ADDRESS <u>4812 GA Ave NW</u>		24a. REC'D BY REGISTRAR <u>SEP 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>		24c. (City, town, or county) <u></u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10270

CERTIFICATE OF DEATH

10272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN TB 22 hours		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 17	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. + Hosp.		d. STREET ADDRESS 6800 Red Top Rd.	
3. NAME OF DECEASED (Type or print) First Philip Middle Martin Last Bashwiner		4. DATE OF DEATH Month SEPT. Day 15 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/82
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 11 Days 27	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired pressman		10b. KIND OF BUSINESS OR INDUSTRY Pressman	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Martin Bashwiner		14. MOTHER'S MAIDEN NAME Isabel Carpenter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT pt. hosp. chart + wife		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MELANOCARCINOMA, PRIMARY - COLON 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) WITH METASTASIS TO LUNGS, BLADDER, LIVER DUE TO (c) AND LEFT PYLORETIC AND PYONEPHROSIS INTERVAL BETWEEN ONSET AND DEATH MONTHS 11			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 1957, to Sept , 1958, that I last saw the deceased alive on Sept 15 , 1958, and that death occurred at 3:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest A. Sarooms		ADDRESS (Street, city or town, state) 7006 New Hampshire Ave. Tk. Pk. Md.	
DATE SIGNED 9/15/58		M.D. 	
PHYSICIAN'S NAME (Type) Ernest A Sarooms 7006 New Hampshire Ave. Tk. Pk. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/18/58	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED John Doe SEX Male AGE 45 RACE White

DATE OF DEATH Jan 15 1924 PLACE OF DEATH Home

CAUSE OF DEATH Heart Disease DISEASE OR INJURY Myocardial Infarction

PERIOD OF ILLNESS 2 weeks PREVIOUS ILLNESS None

DATE OF BIRTH Nov 10 1878 PLACE OF BIRTH Maryland

EDUCATION High School OCCUPATION Teacher

RELIGION Methodist MARITAL STATUS Married

DATE OF MARRIAGE Jan 10 1905 NAME OF SPOUSE Jane Doe

DATE OF DEATH Jan 15 1924 TIME OF DEATH 10:30 AM

PLACE OF DEATH Home NAME OF PHYSICIAN Dr. J. H. Smith

DATE OF EXAMINATION Jan 16 1924 NAME OF EXAMINER Dr. J. H. Smith

DATE OF INTERMENT Jan 17 1924 NAME OF INTERMENT St. Mary's

DATE OF BURIAL Jan 17 1924 NAME OF BURIAL St. Mary's

DATE OF CREMATION None NAME OF CREMATION None

DATE OF EXHUMATION None NAME OF EXHUMATION None

DATE OF REINTERMENT None NAME OF REINTERMENT None

DATE OF REBURIAL None NAME OF REBURIAL None

DATE OF RECREMATION None NAME OF RECREMATION None

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10312

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>45 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>813 Univ. Blvd</u>		d. STREET ADDRESS <u>813 Univ. Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>Amy Lavinia Beall</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-8-95</u>
9. AGE (In years last birthday) <u>62 yrs.</u>		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. W. Mullikin</u>		14. MOTHER'S MAIDEN NAME <u>Leona ^{NEW} Van Horn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Wilma Lewis -</u>		Address <u>Stun -</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>210x Diabetic Mellitus</u> <u>30 yrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>9-8-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 10 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Wash. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Thane</u>	
ADDRESS <u>4812 GA Ave NW</u>		DATE <u>SEP 10 '58</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

IN THE CITY OF NEW YORK
DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Age: _____ Sex: _____

3. Date of Death: _____

4. Place of Death: _____

5. Cause of Death: _____

6. Manner of Death: _____

7. Signature of Medical Examiner: _____

8. Signature of Coroner: _____

9. Signature of Registrar: _____

10. Signature of Burial Officer: _____

11. Signature of Undertaker: _____

12. Signature of Witness: _____

13. Signature of Physician: _____

14. Signature of Nurse: _____

15. Signature of Chaplain: _____

16. Signature of Minister: _____

17. Signature of Priest: _____

18. Signature of Rabbi: _____

19. Signature of Imam: _____

20. Signature of Other: _____

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 529 Eames Place, N. E.	
3. NAME OF DECEASED (Type or print) First Lillie Mae Middle Roebuck Last BELCHER		4. DATE OF DEATH Month September Day 19 Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 September 1922
9. AGE (In years lost birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Elizah ROUNTREE		14. MOTHER'S MAIDEN NAME Lula HENDERSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Husband) Joe N. BELCHER		Address (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 15 September, 1958 , to 19 September 1958 , that I last saw the deceased alive on 19 September 1958 , and that death occurred at 7:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, Bethesda, Md. 9-20-58			
ACTUAL SIGNATURE Douglas R. Koth M.D. U. S. Naval Hospital, Bethesda, Md. 9-20-58			
PHYSICIAN'S NAME (Type) Douglas R. KOTH LT MC USN U. S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-24-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE SPANGLER Funeral Home, 524 8th St., N. E. Wash. D. C.		24a. REC'D BY REGISTRAR SEP 23 58	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G233 9-15-58 et

10314

CERTIFICATE OF DEATH

10275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS Seven Locks Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Grace Middle Blockson Last Blockson				4. DATE OF DEATH Month September Day 4 Year 1958			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1901	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 57 Days 1 Hours 1 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Geneviva Mason			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Jenny Wells (friend)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 week unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1958 , to Sept 3, 1958 , that I last saw the deceased alive on Sept 3, 1958 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE E. Bonditch Hunter M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Sept 11		Soldiers Home		Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snow				24. REC'D BY REGISTRAR SEP 11 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hunter	

CERTIFICATE OF DEATH

1931

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MEDICAL ATTENDANT		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF CLERK	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10276

10315

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>1 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>56</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12621 Epping Rd</u>				d. STREET ADDRESS <u>12623 Epping Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Joseph Boland</u> First Middle Last				4. DATE OF DEATH <u>Sept 29 1958</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-28-07</u>	
				9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Marshall</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Mass</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Wm Henry Boland</u>				14. MOTHER'S MAIDEN NAME <u>Mary Driscoll</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> <u>WW # 2</u>				16. SOCIAL SECURITY NO. <u>579-22-3084</u>		17. INFORMANT <u>Gladys Boland (wife)</u> Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>10/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	
				22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Burke</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>OCT 1 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10212

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>
RESIDENCE <i>123 Main St, Baltimore, Md</i>		DATE OF DEATH <i>Jan 15, 1921</i>	
PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Myocardial Infarction</i>	
MANNER OF DEATH <i>Natural</i>		MEDICAL HISTORY <i>None</i>	
SIGNS AND SYMPTOMS <i>None</i>		POST-MORTEM EXAMINATION <i>None</i>	
FINDINGS <i>None</i>		REMARKS <i>None</i>	
SIGNATURE OF EXAMINER <i>John Doe</i>		DATE <i>Jan 15, 1921</i>	
OFFICE OF THE MEDICAL EXAMINER <i>Baltimore, Md</i>		COUNTY <i>Baltimore</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10316 Item 9 Film G23h 9/24/58 gpi
CERTIFICATE OF DEATH

Reg. Dist. No.

10277

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON MD</u> c. LENGTH OF STAY IN 1b <u>47x-3</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME KENSINGTON GARDEN NURSING</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>2406 19th St NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WUNIA</u> Middle <u>G</u> Last <u>BOOKWALTER</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>4th</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 24 1883</u>	
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MISSIONARY</u>		12. KIND OF BUSINESS OR INDUSTRY <u>CHOF SOUTH INDIA</u>	
13. BIRTHPLACE (State or foreign country) <u>KNOXVILLE TENN.</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>NEWIS BOOKWALTER</u>		16. MOTHER'S MAIDEN NAME <u>EMMA GUITNER</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. INFORMANT <u>MRS RUTH HUMMEH</u>		Address <u>2406 19th St NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 13</u> , 19 <u>58</u> , to <u>Sept. 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 4</u> , 19 <u>58</u> , and that death occurred at <u>7:15 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Katharine A. Chapman</u> M.D.		ADDRESS (Street, city or town, state) <u>3924 BRATO AVE KENSINGTON</u> DATE SIGNED <u>Sept 4 1958</u>	
PHYSICIAN'S NAME (Type) <u>KATHARINE A. CHAPMAN</u>		<u>3924 BRATO AVE KENSINGTON MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>SEPT 6 1958</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Swthland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Bink & Sons</u>		ADDRESS <u>3034 M St NW</u>	
24. REC'D BY REGISTRAR <u>SEP 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

1931

NAME OF DECEASED [Faint, illegible text]	
SEX [Faint, illegible text]	
AGE [Faint, illegible text]	
DATE OF DEATH [Faint, illegible text]	
PLACE OF DEATH [Faint, illegible text]	
CAUSE OF DEATH [Faint, illegible text]	
MANNER OF DEATH [Faint, illegible text]	
SIGNATURE OF PHYSICIAN [Faint, illegible text]	
SIGNATURE OF REGISTRAR [Faint, illegible text]	
SIGNATURE OF WITNESS [Faint, illegible text]	
SIGNATURE OF DECEASED [Faint, illegible text]	
SIGNATURE OF NEXT OF KIN [Faint, illegible text]	
SIGNATURE OF BURIAL OFFICER [Faint, illegible text]	
SIGNATURE OF CHURCH OFFICER [Faint, illegible text]	
SIGNATURE OF MINISTER [Faint, illegible text]	
SIGNATURE OF CLERGYMAN [Faint, illegible text]	
SIGNATURE OF OTHER [Faint, illegible text]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10278

Reg. Dist. No.

10317

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b X Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9404 Kingsley Ave		d. STREET ADDRESS 9404 Kingsley Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARIANNA Middle BORZI Last BORZI		4. DATE OF DEATH Month Sept Day 26 Year 1958	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/8/1883	
9. AGE (in years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 9 Days 18	
11. IF UNDER 24 HRS. Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Italy	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul R Borzi		14. MOTHER'S MAIDEN NAME Santa Calderaro	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-46-8824B	
17. INFORMANT Mary G Borzi Dtr Same # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart disease 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardio - renal disease DUE TO (c) Carcinoma of left breast with metasyasis			
INTERVAL BETWEEN ONSET AND DEATH minutes 1 mo. 7 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/26/58	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/58	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR SEP 30 '58	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. SMITH		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH Jan 15, 1925		6. PLACE OF DEATH Home	
7. OCCUPATION Carpenter		8. CAUSE OF DEATH Heart Disease	
9. MANNER OF DEATH Natural		10. SIGNATURE OF EXAMINER J. H. Smith	
11. SIGNATURE OF WITNESSES J. H. Smith		12. SIGNATURE OF CORONER J. H. Smith	
13. SIGNATURE OF CLERK J. H. Smith		14. SIGNATURE OF JURY J. H. Smith	
15. SIGNATURE OF JURY J. H. Smith		16. SIGNATURE OF JURY J. H. Smith	
17. SIGNATURE OF JURY J. H. Smith		18. SIGNATURE OF JURY J. H. Smith	
19. SIGNATURE OF JURY J. H. Smith		20. SIGNATURE OF JURY J. H. Smith	
21. SIGNATURE OF JURY J. H. Smith		22. SIGNATURE OF JURY J. H. Smith	
23. SIGNATURE OF JURY J. H. Smith		24. SIGNATURE OF JURY J. H. Smith	
25. SIGNATURE OF JURY J. H. Smith		26. SIGNATURE OF JURY J. H. Smith	
27. SIGNATURE OF JURY J. H. Smith		28. SIGNATURE OF JURY J. H. Smith	
29. SIGNATURE OF JURY J. H. Smith		30. SIGNATURE OF JURY J. H. Smith	
31. SIGNATURE OF JURY J. H. Smith		32. SIGNATURE OF JURY J. H. Smith	
33. SIGNATURE OF JURY J. H. Smith		34. SIGNATURE OF JURY J. H. Smith	
35. SIGNATURE OF JURY J. H. Smith		36. SIGNATURE OF JURY J. H. Smith	
37. SIGNATURE OF JURY J. H. Smith		38. SIGNATURE OF JURY J. H. Smith	
39. SIGNATURE OF JURY J. H. Smith		40. SIGNATURE OF JURY J. H. Smith	
41. SIGNATURE OF JURY J. H. Smith		42. SIGNATURE OF JURY J. H. Smith	
43. SIGNATURE OF JURY J. H. Smith		44. SIGNATURE OF JURY J. H. Smith	
45. SIGNATURE OF JURY J. H. Smith		46. SIGNATURE OF JURY J. H. Smith	
47. SIGNATURE OF JURY J. H. Smith		48. SIGNATURE OF JURY J. H. Smith	
49. SIGNATURE OF JURY J. H. Smith		50. SIGNATURE OF JURY J. H. Smith	
51. SIGNATURE OF JURY J. H. Smith		52. SIGNATURE OF JURY J. H. Smith	
53. SIGNATURE OF JURY J. H. Smith		54. SIGNATURE OF JURY J. H. Smith	
55. SIGNATURE OF JURY J. H. Smith		56. SIGNATURE OF JURY J. H. Smith	
57. SIGNATURE OF JURY J. H. Smith		58. SIGNATURE OF JURY J. H. Smith	
59. SIGNATURE OF JURY J. H. Smith		60. SIGNATURE OF JURY J. H. Smith	
61. SIGNATURE OF JURY J. H. Smith		62. SIGNATURE OF JURY J. H. Smith	
63. SIGNATURE OF JURY J. H. Smith		64. SIGNATURE OF JURY J. H. Smith	
65. SIGNATURE OF JURY J. H. Smith		66. SIGNATURE OF JURY J. H. Smith	
67. SIGNATURE OF JURY J. H. Smith		68. SIGNATURE OF JURY J. H. Smith	
69. SIGNATURE OF JURY J. H. Smith		70. SIGNATURE OF JURY J. H. Smith	
71. SIGNATURE OF JURY J. H. Smith		72. SIGNATURE OF JURY J. H. Smith	
73. SIGNATURE OF JURY J. H. Smith		74. SIGNATURE OF JURY J. H. Smith	
75. SIGNATURE OF JURY J. H. Smith		76. SIGNATURE OF JURY J. H. Smith	
77. SIGNATURE OF JURY J. H. Smith		78. SIGNATURE OF JURY J. H. Smith	
79. SIGNATURE OF JURY J. H. Smith		80. SIGNATURE OF JURY J. H. Smith	
81. SIGNATURE OF JURY J. H. Smith		82. SIGNATURE OF JURY J. H. Smith	
83. SIGNATURE OF JURY J. H. Smith		84. SIGNATURE OF JURY J. H. Smith	
85. SIGNATURE OF JURY J. H. Smith		86. SIGNATURE OF JURY J. H. Smith	
87. SIGNATURE OF JURY J. H. Smith		88. SIGNATURE OF JURY J. H. Smith	
89. SIGNATURE OF JURY J. H. Smith		90. SIGNATURE OF JURY J. H. Smith	
91. SIGNATURE OF JURY J. H. Smith		92. SIGNATURE OF JURY J. H. Smith	
93. SIGNATURE OF JURY J. H. Smith		94. SIGNATURE OF JURY J. H. Smith	
95. SIGNATURE OF JURY J. H. Smith		96. SIGNATURE OF JURY J. H. Smith	
97. SIGNATURE OF JURY J. H. Smith		98. SIGNATURE OF JURY J. H. Smith	
99. SIGNATURE OF JURY J. H. Smith		100. SIGNATURE OF JURY J. H. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G234 9/24/58 ggi

CERTIFICATE OF DEATH

Item 13, Film G-234 9/30/58, cac.

Reg. Dist. No.

10279

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 5303 Clark Place				f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Jennie		Middle Elizabeth		Last Bowers		4. DATE OF DEATH Month September	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1921		9. AGE (In years last birthday) 37	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Anthony Hanczarek				14. MOTHER'S MAIDEN NAME Tekla Knopik					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 035-18-2815		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intra cerebral hemorrhage DUE TO (c) Acute Myelocytic Leukemia								INTERVAL BETWEEN ONSET AND DEATH 5 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 11, 1958 , to September 17, 1958 , that I last saw the deceased alive on September 17, 1958 , and that death occurred at 6:40 P. M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE Arthur L. Teplitzky				M.D. The Clinical Center				DATE SIGNED 9/18/58	
PHYSICIAN'S NAME (Type) Arthur L. Teplitzky, M.D.				ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-22-58		22c. NAME OF CEMETERY OR CREMATORY Huntington Nat'l.		22d. LOCATION (City, town, or county) (State) St. Myer, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambliss, Jr.				ADDRESS 517 N. ST. SE Washington, D.C.		24a. REC'D BY REGISTRAR SEP 22 1958		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10319

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Springfield			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5606 Parkston Road				d. STREET ADDRESS 5606 Parkston Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MARY JOSEPHINE BROADBENT				4. DATE OF DEATH Month Day Year Sept. 3, 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 8 8	IF UNDER 24 HRS. 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Ryder				14. MOTHER'S MAIDEN NAME Margaret ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Leonard S. Broadbent-same as item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS, GENERAL DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 7 MO. 4 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 9, 1956 , to SEPT. 3, 1958 , that I last saw the deceased alive on SEPT. 2, 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leo M. Curtis M.D. 9-3-58							
ACTUAL SIGNATURE Leo M. Curtis				PHYSICIAN'S NAME (Type) Leo M. Curtis -8218 Wisconsin Avenue, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/58		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE SEP 5 '58		24b. REGISTRAR'S SIGNATURE Charles S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove casket papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10320

CERTIFICATE OF DEATH

10281.
 Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 43 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Waite Orville Last BUNKER				4. DATE OF DEATH Month September Day 17 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 February 1882	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles BUNKER				14. MOTHER'S MAIDEN NAME Isola BEASSWELE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I & II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Eleanor G. BUNKER (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH 3-4 hrs Many Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction Curious of heart.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 August 19 58 to 17 September 19 58 , that I last saw the deceased alive on 17 September 19 58 , and that death occurred at 1:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.J. Pearson, Jr.				DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-17-58			
PHYSICIAN'S NAME (Type) R.J. Pearson, Jr. CAPT, MC, USN				ADDRESS U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-22-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md				24a. REC'D BY REGISTRAR SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

CERTIFICATE OF DEATH

1935

<p>1. Name of deceased (Print name and surname) _____</p>		<p>2. Sex _____</p>		<p>3. Age _____</p>	
<p>4. Date of birth _____</p>		<p>5. Place of birth _____</p>		<p>6. Usual residence _____</p>	
<p>7. Date of death _____</p>		<p>8. Time of death _____</p>		<p>9. Place of death _____</p>	
<p>10. Cause of death (State immediately and briefly) _____</p>		<p>11. Nature of disease or injury (State fully) _____</p>		<p>12. Duration of disease or injury (State fully) _____</p>	
<p>13. Name of attending physician _____</p>		<p>14. Name of medical examiner _____</p>		<p>15. Name of coroner _____</p>	
<p>16. Signature of attending physician _____</p>		<p>17. Signature of medical examiner _____</p>		<p>18. Signature of coroner _____</p>	
<p>19. Name of registrar _____</p>		<p>20. Name of clerk _____</p>		<p>21. Name of stenographer _____</p>	
<p>22. Name of nurse _____</p>		<p>23. Name of janitor _____</p>		<p>24. Name of porter _____</p>	
<p>25. Name of driver _____</p>		<p>26. Name of messenger _____</p>		<p>27. Name of other person _____</p>	
<p>28. Name of other person _____</p>		<p>29. Name of other person _____</p>		<p>30. Name of other person _____</p>	
<p>31. Name of other person _____</p>		<p>32. Name of other person _____</p>		<p>33. Name of other person _____</p>	
<p>34. Name of other person _____</p>		<p>35. Name of other person _____</p>		<p>36. Name of other person _____</p>	
<p>37. Name of other person _____</p>		<p>38. Name of other person _____</p>		<p>39. Name of other person _____</p>	
<p>40. Name of other person _____</p>		<p>41. Name of other person _____</p>		<p>42. Name of other person _____</p>	
<p>43. Name of other person _____</p>		<p>44. Name of other person _____</p>		<p>45. Name of other person _____</p>	
<p>46. Name of other person _____</p>		<p>47. Name of other person _____</p>		<p>48. Name of other person _____</p>	
<p>49. Name of other person _____</p>		<p>50. Name of other person _____</p>		<p>51. Name of other person _____</p>	
<p>52. Name of other person _____</p>		<p>53. Name of other person _____</p>		<p>54. Name of other person _____</p>	
<p>55. Name of other person _____</p>		<p>56. Name of other person _____</p>		<p>57. Name of other person _____</p>	
<p>58. Name of other person _____</p>		<p>59. Name of other person _____</p>		<p>60. Name of other person _____</p>	
<p>61. Name of other person _____</p>		<p>62. Name of other person _____</p>		<p>63. Name of other person _____</p>	
<p>64. Name of other person _____</p>		<p>65. Name of other person _____</p>		<p>66. Name of other person _____</p>	
<p>67. Name of other person _____</p>		<p>68. Name of other person _____</p>		<p>69. Name of other person _____</p>	
<p>70. Name of other person _____</p>		<p>71. Name of other person _____</p>		<p>72. Name of other person _____</p>	
<p>73. Name of other person _____</p>		<p>74. Name of other person _____</p>		<p>75. Name of other person _____</p>	
<p>76. Name of other person _____</p>		<p>77. Name of other person _____</p>		<p>78. Name of other person _____</p>	
<p>79. Name of other person _____</p>		<p>80. Name of other person _____</p>		<p>81. Name of other person _____</p>	
<p>82. Name of other person _____</p>		<p>83. Name of other person _____</p>		<p>84. Name of other person _____</p>	
<p>85. Name of other person _____</p>		<p>86. Name of other person _____</p>		<p>87. Name of other person _____</p>	
<p>88. Name of other person _____</p>		<p>89. Name of other person _____</p>		<p>90. Name of other person _____</p>	
<p>91. Name of other person _____</p>		<p>92. Name of other person _____</p>		<p>93. Name of other person _____</p>	
<p>94. Name of other person _____</p>		<p>95. Name of other person _____</p>		<p>96. Name of other person _____</p>	
<p>97. Name of other person _____</p>		<p>98. Name of other person _____</p>		<p>99. Name of other person _____</p>	
<p>100. Name of other person _____</p>		<p>101. Name of other person _____</p>		<p>102. Name of other person _____</p>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10321

Item 14 Film 0233 9/19/58 pgt

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN lb <u>1 wk</u>		d. STREET ADDRESS <u>3302 Weller Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3302 Weller Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Patrick Burke</u>		4. DATE OF DEATH <u>Sept 9 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-96</u>
9. AGE (In years last birthday) <u>62 yrs.</u>		IF UNDER YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water front com.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y. state</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>	
13. FATHER'S NAME <u>Edward Patrick Burke</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>092/05-3171</u>	
17. INFORMANT <u>Edw. Burke (son)</u>		Address <u>Stun 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Biosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BIOSCH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH OFF

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>	RACE <i>White</i>
DATE OF DEATH <i>Jan 15 1924</i>		TIME OF DEATH <i>10:30 AM</i>	PLACE OF DEATH <i>Home</i>	
RESIDENCE <i>123 Main St, Baltimore, Md</i>		OCCUPATION <i>Teacher</i>		
CAUSE OF DEATH <i>Myocardial Infarction</i>				
MANNER OF DEATH <i>Natural</i>				
SIGNATURE OF EXAMINER <i>John Doe</i>				
DATE OF EXAMINATION <i>Jan 15 1924</i>				
PLACE OF EXAMINATION <i>Home</i>				
SIGNATURE OF WITNESS <i>John Doe</i>				
DATE OF WITNESS <i>Jan 15 1924</i>				
PLACE OF WITNESS <i>Home</i>				
SIGNATURE OF SECOND WITNESS <i>John Doe</i>				
DATE OF SECOND WITNESS <i>Jan 15 1924</i>				
PLACE OF SECOND WITNESS <i>Home</i>				
SIGNATURE OF THIRD WITNESS <i>John Doe</i>				
DATE OF THIRD WITNESS <i>Jan 15 1924</i>				
PLACE OF THIRD WITNESS <i>Home</i>				
SIGNATURE OF FOURTH WITNESS <i>John Doe</i>				
DATE OF FOURTH WITNESS <i>Jan 15 1924</i>				
PLACE OF FOURTH WITNESS <i>Home</i>				
SIGNATURE OF FIFTH WITNESS <i>John Doe</i>				
DATE OF FIFTH WITNESS <i>Jan 15 1924</i>				
PLACE OF FIFTH WITNESS <i>Home</i>				
SIGNATURE OF SIXTH WITNESS <i>John Doe</i>				
DATE OF SIXTH WITNESS <i>Jan 15 1924</i>				
PLACE OF SIXTH WITNESS <i>Home</i>				
SIGNATURE OF SEVENTH WITNESS <i>John Doe</i>				
DATE OF SEVENTH WITNESS <i>Jan 15 1924</i>				
PLACE OF SEVENTH WITNESS <i>Home</i>				
SIGNATURE OF EIGHTH WITNESS <i>John Doe</i>				
DATE OF EIGHTH WITNESS <i>Jan 15 1924</i>				
PLACE OF EIGHTH WITNESS <i>Home</i>				
SIGNATURE OF NINTH WITNESS <i>John Doe</i>				
DATE OF NINTH WITNESS <i>Jan 15 1924</i>				
PLACE OF NINTH WITNESS <i>Home</i>				
SIGNATURE OF TENTH WITNESS <i>John Doe</i>				
DATE OF TENTH WITNESS <i>Jan 15 1924</i>				
PLACE OF TENTH WITNESS <i>Home</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10322

CERTIFICATE OF DEATH

Reg. Dist. No.

10283

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C. MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomena's Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET CAESAR</u>				4. DATE OF DEATH Month Day Year <u>Sept 21- 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21-1870</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.B.</u>	
13. FATHER'S NAME <u>Wm. Ponder</u>				14. MOTHER'S MAIDEN NAME <u>Mary Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Wm. J. Caesar</u> Address <u>1229-29th St. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>20 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 13, 1958</u> to <u>Sept. 21, 1958</u> that I last saw the deceased alive on <u>Sept. 16, 1958</u> and that death occurred at <u>3:50 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2205 Richland St. Silver Spring, Md.</u> DATE SIGNED <u>9-21-58</u>							
ACTUAL SIGNATURE <u>Harry J. Kicherer</u> M.D.				PHYSICIAN'S NAME (Type) <u>Harry J. Kicherer</u> <u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 25, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Agnes Funeral Home</u> ADDRESS <u>2224 Miss</u>				24a. REC'D BY REGISTRAR <u>SEP 26 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

10352

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Time of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
JAMES H. SMITH		Male		45		Jan 15 1900		Baltimore, Md.		Baltimore, Md.		Heart disease		Jan 15 1945		10:00 AM		J. H. Smith		J. H. Smith		J. H. Smith	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Signature of informant		20. Date of completion		21. Time of completion		22. Signature of registrar		23. Date of registration		24. Time of registration	
J. H. Smith		Son		1234 Main St.		Baltimore		Md.		21201		J. H. Smith		Jan 15 1945		10:00 AM		J. H. Smith		Jan 15 1945		10:00 AM	

MD-10352-1-45

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Place of birth
6. Usual residence
7. Cause of death
8. Date of death
9. Time of death
10. Signature of physician
11. Signature of registrar
12. Signature of informant
13. Name of informant
14. Relationship
15. Address
16. City
17. State
18. Zip
19. Signature of informant
20. Date of completion
21. Time of completion
22. Signature of registrar
23. Date of registration
24. Time of registration

10323

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON. D.C.			
				d. STREET ADDRESS 2001 16th St. N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ESTELLE B CAMPBELL				4. DATE OF DEATH Month SEPT. Day 21 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/3/78	
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months 21 Days 21 Hours 19 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Buffalo, New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME George Ball				14. MOTHER'S MAIDEN NAME Mary Cohn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Son (Geo. Campbell)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Posterior Septal + Posterior Left Ventricle 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Coronary Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 48 48 Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19 a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Warren, Pa.				20g. (County) Warren, Pa.		20h. (State) Pa.	
21. I certify that I attended the deceased from 1938 to Sept 21 19 58 , that I last saw the deceased alive on 21 Sept 19 58 , and that death occurred at 9:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Warren, Pa. DATE SIGNED John G. Ball							
ACTUAL SIGNATURE John G. Ball				M.D. John G. Ball			
PHYSICIAN'S NAME (Type) JOHN G. BALL 7936 Old Georgetown Rd. Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
removal		9/22/58		Oakland Cemetery		Warren, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company				24a. REC'D BY REGISTRAR SEP 23 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

10323

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

10323

1. NAME OF DECEASED JOHN A. BELL		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1898		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Farmer		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. DATE OF DEATH 1963		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural	
16. SIGNATURE OF PHYSICIAN J. A. Smith		17. SIGNATURE OF REGISTRAR J. B. Jones		18. SIGNATURE OF DECEASED J. A. Bell		19. SIGNATURE OF NEXT OF KIN J. B. Jones		20. SIGNATURE OF WITNESSES J. C. Doe, J. D. Roe	

10323

10323

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
c. LENGTH OF STAY IN 1b 9 days		d. STREET ADDRESS 5908 Cedar Parkway	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle Francis Last Carroll Jr.		4. DATE OF DEATH Month September Day 21 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 28, 1911
9. AGE (In years last birthday) 47/46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Francis Carroll		14. MOTHER'S MAIDEN NAME Annie Ryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. same	
17. INFORMANT Mary H. Carroll		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured Esophageal Varices (c) Cirrhosis of Liver		INTERVAL BETWEEN ONSET AND DEATH Immediate Immediate Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-19 , 19 58 , to 9-21 , 19 58 , that I last saw the deceased alive on 9-20 , 19 58 , and that death occurred at 6:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Fleet Lickett		ADDRESS (Street, city or town, state) 5800 Penn Rd NW DATE SIGNED 9-21-58	
PHYSICIAN'S NAME (Type) W. FLEET LICKETT			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-24-1958	22c. NAME OF CEMETERY OR CREMATORY Mt. OLIVER	22d. LOCATION (City, town, or county) (State) WASH., D.C.
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan		ADDRESS 317 Penn Ave SE	
24a. REC'D BY REGISTRAR DATE SEP 23 '58		24b. REGISTRAR'S SIGNATURE William S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. NAME OF DECEASED WILLIAM		2. SEX Male		3. AGE 30		4. RACE White		5. BIRTH DATE 1910		6. BIRTH PLACE Maryland		7. MARITAL STATUS Single		8. OCCUPATION Student	
9. DATE OF DEATH 1940		10. TIME OF DEATH 10:00 AM		11. PLACE OF DEATH Home		12. CAUSE OF DEATH Pneumonia		13. DISEASE OR INJURY Pneumonia		14. IMMEDIATE CAUSE Pneumonia		15. UNDERLYING CAUSE Pneumonia		16. MANNER OF DEATH Natural	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF REGISTRAR		21. SIGNATURE OF CLERK		22. SIGNATURE OF JUDGE		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF CORONER	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND STATISTICAL PURPOSES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10286

10325

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 7 hrs. 5mins. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County Gen. Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ella Mae Carter				4. DATE OF DEATH Month Day Year 9- 28 1958			
5. SEX Female		6. COLOR OR RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Clifton Edward Thomas				14. MOTHER'S MAIDEN NAME Mary Simpson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Eugene Carter Sandy Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X Subdural Hematoma and DUE TO Subarachnoid hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Subarachnoid hemorrhage DUE TO (c) Subarachnoid hemorrhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Broncho-pneumonia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 7/28 , 19 58 , to 9/28 , 19 58 , that I last saw the deceased alive on 9/28/58 , 19 58 , and that death occurred at 1:35 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 9/30/58 ACTUAL SIGNATURE A. D. Bonifant PHYSICIAN'S NAME (Type) A. D. Bonifant							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-2-58		22c. NAME OF CEMETERY OR CREMATORY Sandy Spring		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE OCT 6 1958	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10287

10326

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 1 Glen Hills	
3. NAME OF DECEASED (Type or print) S First Minnie Middle M Last Cavanaugh		4. DATE OF DEATH September 4 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 12, 1892
9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME ALEXANDRA GOROUN		14. MOTHER'S MAIDEN NAME Hattie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-16-9319A	
17. INFORMANT Mr. Bernard Cavanaugh-same as item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cachexia DUE TO (c) Metastatic Ca from uterus		INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 wk 9 mon	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1, 1957 to 9/4/1958 , that I last saw the deceased alive on 9/4/1958 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md DATE SIGNED 9/4/58			
ACTUAL SIGNATURE Stephen N. Jones M.D.		PHYSICIAN'S NAME (Type) Stephen N. Jones Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/58	
22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 9 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

10055

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH April 10, 1941		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN J. H. HARRIS	
10. SIGNATURE OF REGISTRAR J. H. HARRIS		11. SIGNATURE OF WITNESSES J. H. HARRIS		12. SIGNATURE OF DECEASED J. H. HARRIS	
13. SIGNATURE OF FUNERAL HOME J. H. HARRIS		14. SIGNATURE OF BURIAL PLACE J. H. HARRIS		15. SIGNATURE OF INTERVIEWER J. H. HARRIS	
16. SIGNATURE OF CORONER J. H. HARRIS		17. SIGNATURE OF JURY J. H. HARRIS		18. SIGNATURE OF JUDGE J. H. HARRIS	
19. SIGNATURE OF CLERK J. H. HARRIS		20. SIGNATURE OF ASSISTANT CLERK J. H. HARRIS		21. SIGNATURE OF RECEPTIONIST J. H. HARRIS	
22. SIGNATURE OF TELEPHONE OPERATOR J. H. HARRIS		23. SIGNATURE OF MAIL ROOM J. H. HARRIS		24. SIGNATURE OF RECORDS SECTION J. H. HARRIS	
25. SIGNATURE OF CHIEF OF BUREAU J. H. HARRIS		26. SIGNATURE OF DEPUTY CHIEF J. H. HARRIS		27. SIGNATURE OF ASSISTANT DEPUTY J. H. HARRIS	
28. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		29. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		30. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
31. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		32. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		33. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
34. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		35. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		36. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
37. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		38. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		39. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
40. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		41. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		42. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
43. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		44. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		45. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
46. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		47. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		48. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
49. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		50. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		51. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
52. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		53. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		54. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
55. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		56. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		57. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
58. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		59. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		60. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
61. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		62. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		63. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
64. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		65. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		66. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
67. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		68. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		69. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
70. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		71. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		72. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
73. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		74. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		75. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
76. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		77. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		78. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
79. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		80. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		81. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
82. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		83. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		84. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
85. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		86. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		87. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
88. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		89. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		90. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
91. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		92. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		93. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
94. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		95. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		96. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
97. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		98. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		99. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	
100. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		101. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		102. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10327

CERTIFICATE OF DEATH

10288
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 9 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		83X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 4323 Raleigh Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last CHOPLOSKY		4. DATE OF DEATH Month September Day 8 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 August 1958
9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Joseph CHOPLOSKY		14. MOTHER'S MAIDEN NAME Mary Elizabeth BRUBAKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) John H. CHOPLOSKY (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial Meningitis, acute. 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Meningococci, cerebrospinal DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day 7 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 Aug , 19 58 , to 8 Sept. , 19 58 , that I last saw the deceased alive on 8 SEPT. , 19 58 , and that death occurred at 6:05A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-8-58			
ACTUAL SIGNATURE David Harris M.D.			
PHYSICIAN'S NAME (Type) David Harris, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-58	
22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 3072 "M" St, N.W. Washington, D.C.		24. REGISTRAR'S SIGNATURE Arthur L. Harris	
25. REC'D BY REGISTRAR SEP 10 '58			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10289

10328

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1725 Beall Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Leo</u> Last <u>Christy</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/8/18</u>
9. AGE (In years last birthday) yrs. <u>40</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>22</u> Hours <u>12</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bethesda, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leo E. Christy</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Mc Fadden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Chart of mother</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Atelectasis, obstructive</u> <u>760.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arachnoid hemorrhage, vertex</u> (c) <u>Birth trauma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few hrs</u> <u>1+ day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital heart lesion - Patent foramen ovale</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>ductus arteriosus</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 8</u> , 19 <u>58</u> , to <u>Sept 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 9</u> , 19 <u>58</u> , and that death occurred at <u>11:55 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen C. Cromwell</u>		M.D. <u>615 W. Montgomery Ave. Rockville Md.</u>	
PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell</u>		<u>615 W. Montgomery Ave. Rockville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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10329

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Dickenson			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN IB 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Polly Middle Mae Last Church				4. DATE OF DEATH Month September Day 12 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1925	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Edward Newberry				14. MOTHER'S MAIDEN NAME Sarah Owens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X DUE TO Pericardial Hemorrhage, Post Left Atrial Catheterization Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PERICARDIAL HEMORRHAGE, POST LEFT ATRIAL CATHETERIZATION DUE TO (c) 7 year							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic rheumatic valvulitis (CHRONIC RHEUMATIC VALVULITIS)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from September 3, 19 58 , to September 12, 19 58 , that I last saw the deceased alive on September 12, 19 58 , and that death occurred at 6:58 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon I. Goldberg M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/13/58			
PHYSICIAN'S NAME (Type) LEON I. Goldberg, M.D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/58		22c. NAME OF CEMETERY OR CREMATORY Newberry Cem.		22d. LOCATION (City, town, or county) (State) Tarpon, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 18 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. The pages are to be removed from the certificate prior to burial, cremation, or removal, and in any event within 72 hours after death.

10330

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Mercer</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princeton</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>			d. STREET ADDRESS <u>518 Snowden Lane</u>		
3. NAME OF DECEASED (Type or print) First <u>Charlotte</u> Middle <u>Ireland</u> Last <u>Clinton</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1871</u>		9. AGE (In years last birthday) <u>87</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Charles Clinton</u>			14. MOTHER'S MAIDEN NAME <u>Frances Ann Ireland</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>Mrs. John Dickinson</u>			Address <u>Bethesda, Md. 5521 Charles St</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>unknown</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u> <u>Bronchopneumonia</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Aug 30</u> , 19 <u>58</u> , to <u>Sept 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 21</u> , 19 <u>58</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10571 Summit Ave Kensington, Md.</u> DATE SIGNED <u>George Sharpe</u>					
ACTUAL SIGNATURE <u>George Sharpe</u>					
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Thompson</u>			ADDRESS <u>7-57 Thawman Rd</u>		
24a. REC'D BY REGISTRAR <u>SEP 23 '58</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10292

10271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 S. Silver Spring Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospital</u>		d. STREET ADDRESS <u>9604 Evergreen St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Milton</u> Last <u>Collins</u>		4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-85</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer + building Dept.</u>	11. BIRTHPLACE (State or foreign country) <u>D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Collins - Mr. Albert G.</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Adams</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO. <u>719-18-7479</u>		17. INFORMANT Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Carcinoma left lung with metastasis to liver, 2 Pericardial effusion, 3 massive Pulmonary edema</u> DUE TO (b) <u>metastasis to liver</u> DUE TO (c) <u>massive Pulmonary edema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>163X</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 13</u> , 19 <u>58</u> , to <u>Sept 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 2</u> , 19 <u>58</u> , and that death occurred at <u>2:05 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip E. Jones</u>		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>Philip E Jones</u>		DATE SIGNED <u>9-2-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/5/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Humphrey</u>		ADDRESS <u>8434 Gt Ave</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>SEP 5 '58</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF BIRTH: *1930-01-15*

5. PLACE OF BIRTH: *Baltimore, Maryland*

6. OCCUPATION: *Teacher*

7. CAUSE OF DEATH: *Heart Disease*

8. DATE OF DEATH: *1975-03-10*

9. PLACE OF DEATH: *Home*

10. SIGNATURE OF DECEASED: *John Doe*

11. SIGNATURE OF WITNESS: *John Doe*

12. SIGNATURE OF PHYSICIAN: *John Doe*

13. SIGNATURE OF CORONER: *John Doe*

14. SIGNATURE OF REGISTRAR: *John Doe*

15. SIGNATURE OF CLERK: *John Doe*

16. SIGNATURE OF JUDGE: *John Doe*

17. SIGNATURE OF SHERIFF: *John Doe*

18. SIGNATURE OF DISTRICT ATTORNEY: *John Doe*

19. SIGNATURE OF COUNTY CLERK: *John Doe*

20. SIGNATURE OF CITY CLERK: *John Doe*

21. SIGNATURE OF TOWNSHIP CLERK: *John Doe*

22. SIGNATURE OF VILLAGE CLERK: *John Doe*

23. SIGNATURE OF POST OFFICE CLERK: *John Doe*

24. SIGNATURE OF SCHOOL CLERK: *John Doe*

25. SIGNATURE OF CHURCH CLERK: *John Doe*

26. SIGNATURE OF SYNAGOGUE CLERK: *John Doe*

27. SIGNATURE OF MOSQUE CLERK: *John Doe*

28. SIGNATURE OF TEMPLE CLERK: *John Doe*

29. SIGNATURE OF OTHER CLERK: *John Doe*

30. SIGNATURE OF OTHER OFFICIAL: *John Doe*

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10331

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Rodreick Last CONGER		4. DATE OF DEATH Month September Day 23 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 June 1944
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR: Months 14 Days 14 Hours 14 Min. 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Jackson CONGER		14. MOTHER'S MAIDEN NAME Lois Jane RODREICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Henry J. Conger, (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 4 yrs +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 13 Sept. , 19 58 , to 23 Sept. , 19 58 , that I last saw the deceased alive on 23 Sept. , 19 58 , and that death occurred at 2:55A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. C. Parke		DATE SIGNED 9-23-58	
PHYSICIAN'S NAME (Type) J. C. PARKE, JR. LT MC USN		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-58	
22c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cem.		22d. LOCATION (City, town, or county) Norfolk, Virginia (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE J. C. Parke		ADDRESS 1557 Wisconsin Ave., Bethesda, Md.	
24a. REC'D BY REGISTRAR SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thayer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10294

10272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. STREET ADDRESS <u>1 509 BILSCOT PLACE</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Constance</u> First Middle Last		4. DATE OF DEATH <u>9</u> Month <u>6</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-58</u>
9. AGE (In years last birthday) yrs. <u>4</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George L. Cottman</u>		14. MOTHER'S MAIDEN NAME <u>Norma Katherine Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Patent's chart</u>	
17. INFORMANT <u>Patent's chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> <u>760.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cause unknown</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/4</u> , 19 <u>58</u> , to <u>9/6/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/6</u> , 19 <u>58</u> , and that death occurred at <u>2:00</u> M., from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <u>Richard M. Auld</u> M.D.		ADDRESS (Street, city or town, state) <u>909 Viers Mill Rd. Rockville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD M. AULD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 9 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Quinn L. Knaus</u>	

2000

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10295

Reg. Dist. No.

10273

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>DOA.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u> <u>1615-2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u>			d. STREET ADDRESS <u>7981 18th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Blaine</u> Middle <u>Walker</u> Last <u>Covington</u>			4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>7-23-58</u>	9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Octavius M. Covington</u>			14. MOTHER'S MAIDEN NAME <u>Regina B. Barbella</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>suffer Respiratory Infection</u> DUE TO (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>fatal</u> <u>submerged in bed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>		20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-10-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>WASHINGTON</u>		22e. (State) <u>DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Al Don. DeVol</u>		ADDRESS <u>2224-Wis. AVE NW</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

2047293XV8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11471

10332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle CRAVEN Last CRAVEN				4. DATE OF DEATH Month SEPT. Day 16 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/24/10	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House MAN				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME BLANCHE (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant hypertension (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 14 , 19 58 , to Sept 16 , 19 58 , that I last saw the deceased alive on Sept 15 , 19 58 , and that death occurred at 8:10 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED G. Bowditch Hunter Jr. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) BOWDITCH HUNTER JR. 809 Viers Mill Road Rockville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		9/19/58		HAMILTON Cemetery		HAMILTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Muriel Reed By J. L. Reed				ADDRESS Leesburg VA		24a. REC'D BY REGISTRAR DATE NOV 5 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10333 CERTIFICATE OF DEATH

10296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR IN INSTITUTION Marilea Nursing Home		/d. STREET ADDRESS 7301 23rd. Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN CRAWFORD		4. DATE OF DEATH September 17, 1958.	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR: Months 79 Days 79 Hours 79 Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Store clerk	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Crawford		14. MOTHER'S MAIDEN NAME Thelma Johns.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs Thelma E John -		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Barbed Wire Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) yes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 38 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 14, 1958 to Sept 17, 1958 that I last saw the deceased alive on Sept 16, 1958 , and that death occurred at 7:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1917 Seminary Rd. 9-17-58 DATE SIGNED Sept 17, 1958			
ACTUAL SIGNATURE John E. Jones M.D.		PHYSICIAN'S NAME (Type) John E. Jones	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-58	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington, D.C.		24a. REC'D BY REGISTRAR SEP 19 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the can papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10334 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 85 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Wade Last Davis				4. DATE OF DEATH Month September Day 23 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 7, 1894	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Private Industry		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Walter Oliver Davis				14. MOTHER'S MAIDEN NAME Minnie Prosperi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WWI				16. SOCIAL SECURITY NO. 578-24-7820		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO (b) Coronary Arteriosclerosis, Acute Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 420.1							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 30 19 58 , to September 23 19 58 , that I last saw the deceased alive on September 23 19 58 , and that death occurred at 2:35 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/24/58 ACTUAL SIGNATURE Leonard Garren M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Leonard Garren, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 25, 1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va	
23. FUNERAL DIRECTOR'S SIGNATURE C.P. [Signature] ADDRESS Arlington, Va				24a. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur L. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10299

Item 14, Film G234, 10/6/58 Fey

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY 10335 MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1/2 hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8210 PINEY BRANCH ROAD			d. STREET ADDRESS 1601 FOREST GLEN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RICHARD Middle HERMAN Last DIETLE			4. DATE OF DEATH Month SEPTEMBER Day 29 Year 19 58		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/16	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME RICHARD JACOB DIETLE		
14. MOTHER'S MAIDEN NAME Matilda Elizabeth Suanay			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		
16. SOCIAL SECURITY NO.			17. INFORMANT Address Erwin Dietle 10012 Portland Rd. Silver Spring Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & Laceration 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bullet wound thru skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH Found dead in rear room of restaurant
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound thru skull			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 9/29/ 58 —p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) DUTCH'S GRILL	20f. (City or town) (County) (State) SILVER SPRING, MONTGOMERY, MD.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/29/58	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/1/58	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 30 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10335

CERTIFICATE OF DEATH

10300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 156 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4415 Montgomery Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ROBERTO ITALO DONADEI				4. DATE OF DEATH Month Day Year September 7, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 30, 1919	
9. AGE (In years last birthday) 38 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Translator		10b. KIND OF BUSINESS OR INDUSTRY Argentine Government		11. BIRTHPLACE (State or foreign country) Argentina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Valerio Donadei		14. MOTHER'S MAIDEN NAME Josefa Dapero			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 879-42-2533		17. INFORMANT The Medical Record Unascertainable The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 178X Teratocarcinoma, primary in testis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 4, 1958 , to September 7, 1958 , that I last saw the deceased alive on September 7, 1958 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Richard Lee				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) G. RICHARD LEE, M.D.				DATE SIGNED (9/8/58)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-58		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR SEP 15 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Knecht			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

FILE NO.

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ASSISTANT PHYSICIAN

NAME OF PATHOLOGIST

NAME OF ANATOMIST

NAME OF CLERK

NAME OF REGISTRAR

NAME OF ASSISTANT REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF REGISTRAR

NAME OF ASSISTANT REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF REGISTRAR

NAME OF ASSISTANT REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10301

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>P. 9</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hgts 16 X - 2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hosp</u>			d. STREET ADDRESS <u>2110 Keating St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Russell (HMM) Donaldson</u>			4. DATE OF DEATH Month Day Year <u>Sept 17 1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/19/96</u>		9. AGE (In years, last birthday) <u>62 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retail</u>	11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>M. S. C.</u>
13. FATHER'S NAME <u>Edward Donaldson</u>			14. MOTHER'S MAIDEN NAME <u>MINNIE EMMERTT</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>UNK</u>	17. INFORMANT <u>Hosp. Record</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RT. Subdural hematoma and</u> <u>900.0</u> DUE TO (b) <u>left central contusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>fracture of skull</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down steps at daughter's home 8404 Patoma Ave. College Pk md</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> p.m. <u>9/17/58</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) <u>College Pk</u>	(County) <u>P. 9.</u>	(State) <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-17-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>COAR Hill Com</u>	22d. LOCATION (City, town, or county) <u>SWITLAND RD - R. 600 Co. MD</u>	(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Rindale Md.</u>		ADDRESS <u>MD</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10337

CERTIFICATE OF DEATH

Reg. Dist. No.

10302

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 mos. 7 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1214 33rd Street, N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Michael Last DREA		4. DATE OF DEATH Month September Day 8 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 May 1915
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Andrew J. DREA		14. MOTHER'S MAIDEN NAME Mary DWYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 12-19-34 to 6-1-57		16. SOCIAL SECURITY NO. 397 30 8785	
17. INFORMANT (Wife) Mrs. Audree Virginia DREA (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma, Left Lung 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 31 March , 19 58 , to 8 Sept. , 19 58 , that I last saw the deceased alive on 8 Sept. , 19 58 , and that death occurred at 9:25 P. M, from the causes and on the date stated above. ACTUAL SIGNATURE E. J. Rupnik M.D. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-9-58 PHYSICIAN'S NAME (Type) E. J. RUPNIK, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-12-58 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery 22d. LOCATION (City, town, or county) (State) Arlington, Virginia 23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers ADDRESS Chambers, 3072 "M" St., N.W. Washington, D. C. 24a. REC'D BY REGISTRAR SEP 10 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

10033

11

10033

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10303

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>9 yrs</u>		d. STREET ADDRESS <u>1 2615 Elmore st</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2615 Elmore st</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Henry Drury Sr.</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OF FACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-84</u>
9. AGE (In years last birthday) <u>74 yrs.</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> Hours <u>15</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>advertising</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Armour & Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USE</u>	
13. FATHER'S NAME <u>Geo. H. Drury</u>		14. MOTHER'S MAIDEN NAME <u>Eliz. Leamon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-05-4259-A</u>	
17. INFORMANT <u>Marie G. Heintz</u>		Address <u>Stur 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschut</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschut</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9-6-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

10339

CERTIFICATE OF DEATH

10304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden 16 X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home		d. STREET ADDRESS 16 X-2	
3. NAME OF DECEASED (Type or print) First John Middle Dunn Last Dunn		4. DATE OF DEATH Month Sept. Day 20 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Charlotte N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mack Dunn		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Leonie Miller		Address Glenarden, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiorenal disease (c) Hypertensive Cardiorenal disease			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25, 1954 , to Sept. 20, 1958 , that I last saw the deceased alive on Sept. 20, 1958 , and that death occurred at 3:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell		ADDRESS (Street, city or town, state) Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.		DATE SIGNED 9/22/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/23/58	22c. NAME OF CEMETERY OR CREMATORY Glenarden,	22d. LOCATION (City, town, or county) (State) Glenarden, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sward		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR SEP 26 '58
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10340

CERTIFICATE OF DEATH

10305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 4 mo. 11 days 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles E. Dwyer		4. DATE OF DEATH Month Day Year September 29 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/69
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Dwyer		14. MOTHER'S MAIDEN NAME Martha E. Rainne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT William T. Martin		Address 12611 Georgia Ave. Sil.Sp	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelitis Bilateral 610X DUE TO (b) Prostatic Hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Urinary Retention PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 year 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/1 , 19 58 , to 9/29 , 19 58 , that I last saw the deceased alive on 9/24 , 19 58 , and that death occurred at 5:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Bird, M. D.		ADDRESS (Street, city or town, state) DATE SIGNED Sandy Spring, Md.	
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.		Sandy Spring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 2 58	22c. NAME OF CEMETERY OR CREMATORY Rockville Union	22d. LOCATION (City, town, or county) (State) Rockville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		24a. REC'D BY REGISTRAR Laytonsville, Md.	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanks		DATE 3 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH - WASHINGTON, D.C.

<p>1. Name of deceased [Illegible]</p>		<p>2. Sex [Illegible]</p>	
<p>3. Date of birth [Illegible]</p>		<p>4. Place of birth [Illegible]</p>	
<p>5. Date of death [Illegible]</p>		<p>6. Place of death [Illegible]</p>	
<p>7. Cause of death [Illegible]</p>		<p>8. Manner of death [Illegible]</p>	
<p>9. Signature of physician [Illegible]</p>		<p>10. Signature of registrar [Illegible]</p>	
<p>11. Signature of informant [Illegible]</p>		<p>12. Signature of witness [Illegible]</p>	
<p>13. Signature of funeral director [Illegible]</p>		<p>14. Signature of undertaker [Illegible]</p>	
<p>15. Signature of cemetery official [Illegible]</p>		<p>16. Signature of burial official [Illegible]</p>	
<p>17. Signature of health officer [Illegible]</p>		<p>18. Signature of coroner [Illegible]</p>	
<p>19. Signature of medical examiner [Illegible]</p>		<p>20. Signature of pathologist [Illegible]</p>	
<p>21. Signature of toxicologist [Illegible]</p>		<p>22. Signature of bacteriologist [Illegible]</p>	
<p>23. Signature of virologist [Illegible]</p>		<p>24. Signature of parasitologist [Illegible]</p>	
<p>25. Signature of epidemiologist [Illegible]</p>		<p>26. Signature of public health nurse [Illegible]</p>	
<p>27. Signature of health department official [Illegible]</p>		<p>28. Signature of local health officer [Illegible]</p>	
<p>29. Signature of state health officer [Illegible]</p>		<p>30. Signature of federal health officer [Illegible]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10341

CERTIFICATE OF DEATH

10306

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN b <i>8 days</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park</i> d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Ellie Genevieve Edwards</i>		4. DATE OF DEATH Month Day Year <i>9 4 1958</i>			
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/22/70</i>	9. AGE (In years last birthday) <i>88</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Hugh Peden</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NO</i>		17. INFORMANT <i>Hospt. Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331/x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Infarction, acute</i> DUE TO (c) <i>Cerebro-vascular accident-st.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>10 days.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>9-4</i>	
20f. (City or town) <i>9-4</i>		20g. (County) <i>9-4</i>		20h. (State) <i>9-4</i>	
21. I certify that I attended the deceased from <i>8/27</i> , 19 <i>58</i> , to <i>9-4</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9-3</i> , 19 <i>58</i> , and that death occurred at <i>5:25 AM</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Ernest A. Sarao</i>		ADDRESS (Street, city or town, state) <i>7006 New Hampshire Ave Takoma Park</i>		DATE SIGNED <i>9-4-58</i>	
PHYSICIAN'S NAME (Type) <i>ERNEST A. SARAO</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 7, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Salem Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Winston Salem, North Carolina</i>		22e. (State) <i>North Carolina</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		ADDRESS <i>254 Carroll Street NE</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 5 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>					



CERTIFICATE OF DEATH

Reg. Dist. No.

10342

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3410 Shepherd Street</u>				d. STREET ADDRESS <u>3410 Shepherd Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELEANOR CRAVEN FISHBURN</u>				4. DATE OF DEATH Month Day Year <u>Sept. 1, 19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 7, 1907</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>0 24</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Montana</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>George W. Craven</u>				14. MOTHER'S MAIDEN NAME <u>Martha Arnold</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>530-19-6605</u>		17. INFORMANT Address <u>Cyrus C. Fishborn-Item # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE STOMACH DILATATION</u> <u>199:2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INTESTINAL OBSTRUCTION</u> DUE TO (c) <u>METASTATIC CARCINOMA, PRIMARY UNDETERMINED UNKNOWN</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 HOURS</u> <u>2-3 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>AUG. 14, 1958</u> , to <u>SEPT. 1, 1958</u> , that I last saw the deceased alive on <u>SEPT. 1, 1958</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Duohy</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>7720 Wisconsin Ave, Bethesda, Md 9/1/58</u>			
PHYSICIAN'S NAME (Type) <u>John H. Duohy</u>				<u>7720 Wis. Ave., Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>9/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Cincinnati, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10307

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b X Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emily Middle Russell Last Ford		4. DATE OF DEATH Month September Day 10 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1930
9. AGE (in years last birthday) 27 yrs.		IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min. 27	IF UNDER 24 HRS. Months 27 Days 27 Hours 27 Min. 27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Rome, New York	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dr. Edwin P. Russell		14. MOTHER'S MAIDEN NAME Mazie Shuler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Husband		Address W. Kent Ford, Jr. As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Edema of lungs 241X DUE TO (b) Bronchial pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschart		DATE SIGNED 9-10-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 9/10/58	
22c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		22d. LOCATION (City, town, or county) (State) Clifton Forge, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE SEP 11 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
HEALTH DEPT.

DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1933

NOT TO BE FILLED IN BY THE EXAMINER

DATE OF DEATH

PLACE HERE NAME OF DECEASED

PLACE HERE ADDRESS OF DECEASED

PLACE HERE CITY AND STATE

PLACE HERE COUNTY

PLACE HERE DATE OF DEATH

PLACE HERE TIME OF DEATH

PLACE HERE PLACE OF DEATH

PLACE HERE NAME OF MEDICAL EXAMINER

PLACE HERE SIGNATURE OF MEDICAL EXAMINER

PLACE HERE NAME OF PHYSICIAN

PLACE HERE SIGNATURE OF PHYSICIAN

PLACE HERE NAME OF NURSE

PLACE HERE SIGNATURE OF NURSE

PLACE HERE NAME OF CLERK

PLACE HERE SIGNATURE OF CLERK

PLACE HERE NAME OF JURY

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PLACE HERE NAME OF JURY

PLACE HERE SIGNATURE OF JURY

10344

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5002 Aurora Drive</u>		d. STREET ADDRESS <u>15002 Aurora Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>INFANT PHILIP FRANZ</u>		4. DATE OF DEATH Month Day Year <u>Sept. 24 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4, 1957</u>
9. AGE (In years lost birthday) yrs. <u>11 120</u>		10. IF UNDER 1 YEAR: Months Days Hours Min. <u>11 120</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gerald J. Franz</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN MEEHAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FATHER</u>		Address <u>5002 Aurora Dr. Kens. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub Dural HEMATOMA</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Spontaneous Intracranial Hemorrhage</u> DUE TO (c) <u>INDEFINITE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 1957</u> to <u>Sept. 1958</u> , that I last saw the deceased alive on <u>Sept. 23, 1958</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James M. Moser Jr. M.D. 10001 E. BEXHILL Drive</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>JAMES M. MOSER, Jr. Kensington, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey Funeral Home, Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9VVVVVVVXVV

CERTIFICATE OF DEATH

1934

<p>1. NAME OF DECEASED JAMES M. HARRIS</p>		<p>2. SEX Male</p>	
<p>3. AGE 62</p>		<p>4. DATE OF BIRTH May 10, 1872</p>	
<p>5. PLACE OF BIRTH Baltimore, Md.</p>		<p>6. OCCUPATION Clerk</p>	
<p>7. CAUSE OF DEATH Myocardial Infarction</p>		<p>8. PLACE OF DEATH Home</p>	
<p>9. DATE OF DEATH May 15, 1934</p>		<p>10. TIME OF DEATH 11:00 AM</p>	
<p>11. SIGNATURE OF PHYSICIAN J. H. HARRIS</p>		<p>12. SIGNATURE OF REGISTRAR J. H. HARRIS</p>	
<p>13. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>14. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>15. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>16. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>17. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>18. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>19. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>20. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>21. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>22. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>23. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>24. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>25. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>26. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>27. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>28. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>29. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>30. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>31. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>32. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>33. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>34. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>35. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>36. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>37. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>38. SIGNATURE OF WITNESS J. H. HARRIS</p>	
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<p>41. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>42. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>43. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>44. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>45. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>46. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>47. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>48. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>49. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>50. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>51. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>52. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>53. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>54. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>55. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>56. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>57. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>58. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>59. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>60. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>61. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>62. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>63. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>64. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>65. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>66. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>67. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>68. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>69. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>70. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>71. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>72. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>73. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>74. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>75. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>76. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>77. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>78. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>79. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>80. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>81. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>82. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>83. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>84. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>85. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>86. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>87. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>88. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>89. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>90. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>91. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>92. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>93. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>94. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>95. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>96. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>97. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>98. SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>99. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>100. SIGNATURE OF WITNESS J. H. HARRIS</p>	

10345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookdale</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookdale</u>				d. STREET ADDRESS <u>5013 Brookdale Rd</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nme</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ethel Dodge Frost</u>				4. DATE OF DEATH <u>September 26 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1 June 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nme</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Laurel, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Carroll DeWilton Frost</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Dodge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT <u>Me Helen Robinson (Sister)</u>				Address <u>5013 Brookdale Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of ovary with</u> <u>1750</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized metastasis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nme</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April</u> , 19 <u>56</u> , to <u>26 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>26 Sept</u> , 19 <u>58</u> , and that death occurred at <u>10:45 P</u> M, from the causes and on the date stated above.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-29-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Phillips Church Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY,</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>				DATE <u>SEP 30 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1953

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

and State

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. RACE <i>White</i>		4. DATE OF BIRTH <i>1910</i>		5. PLACE OF BIRTH <i>Johns Hopkins</i>	
6. DATE OF DEATH <i>1953</i>		7. TIME OF DEATH <i>10:00 AM</i>		8. PLACE OF DEATH <i>Home</i>		9. CAUSE OF DEATH <i>Heart Disease</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>		13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>		25. SIGNATURE OF DECEASED <i>John Doe</i>	
26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>	
36. SIGNATURE OF DECEASED <i>John Doe</i>		37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF DECEASED <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF DECEASED <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>		49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>	
51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF DECEASED <i>John Doe</i>	
56. SIGNATURE OF DECEASED <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF DECEASED <i>John Doe</i>	
66. SIGNATURE OF DECEASED <i>John Doe</i>		67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF DECEASED <i>John Doe</i>	
71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>		73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>		79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>		85. SIGNATURE OF DECEASED <i>John Doe</i>	
86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>	
96. SIGNATURE OF DECEASED <i>John Doe</i>		97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10276

CERTIFICATE OF DEATH

Reg. Dist. No. 10311

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nails Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Margaret Elizabeth Ayton Gallagher</u>				4. DATE OF DEATH <u>Sept 16 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 3, 1913</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Curtis Ayton</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Podgett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss L. Ayton</u> Address <u>4617 Georgia Ave NW DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Endometrium (metastatic)</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1955</u> , to <u>Sept 16 1955</u> , that I last saw the deceased alive on <u>Sept 6 1955</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Takoma Park, DC</u> DATE SIGNED <u>9-16-55</u> ACTUAL SIGNATURE <u>Thomas J. Ayton</u> M.D. <u>7701 Carroll Rd</u> PHYSICIAN'S NAME (Type) <u>Takoma Park, DC</u>							
22a. BURIAL—CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9-19-55</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral</u> ADDRESS <u>4812 Georgia Ave NW</u>				24a. REC'D BY REGISTRAR <u>SEP 17 1955</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10275

CERTIFICATE OF DEATH

Reg. Dist. No.

10310

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>412 Ethan Allen Ave</u>	
3. NAME OF DECEASED (Type or print) <u>John Robert Gallahan</u>		4. DATE OF DEATH <u>9 - 29 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-76</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>6 26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Fireman FIRE DEPT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRINCE GEORGES COUNTY</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Samuel Gallahan</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE, ACUTE, MASSIVE, RETROPERITONEAL</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>RUPTURED ABDOMINAL AORTIC ANEURYSM.</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>1 DAY</u> <u>YEARS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 22, 1958</u> , to <u>Sept. 23, 1958</u> , that I last saw the deceased alive on <u>Sept. 23, 1958</u> , and that death occurred at <u>11:35 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>A. F. Thibadeau</u>		M.D. <u>10111 Collesville Rd Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. F. THIBADEAU, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>SEPT. 26, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hysong</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>SEP 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Plumb</u>	

(MARTIN W. HYSONG COMPANY)

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1000		4/4/68		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF EXAMINATION		PLACE OF EXAMINATION		DATE OF REPORT		PLACE OF REPORT	
...		
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF COUNTY CLERK		SIGNATURE OF CITY CLERK		SIGNATURE OF STATE CLERK	
...		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10277

CERTIFICATE OF DEATH

Reg. Dist. No.

10312

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>69X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mathew</u> Middle <u>Frank</u> Last <u>Gallo</u>		4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-87</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>10</u> Hours <u>10</u> Min.	IF UNDER 24 HRS. Months <u>11</u> Days <u>10</u> Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Gallo</u>		14. MOTHER'S MAIDEN NAME <u>Genevieve Calasie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>117-03-5141</u>	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia Terminal</u> 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO <u>Primary carcinoma of ureter and prostate</u> (c) <u>multiple fractures due to accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>3 days</u> <u>15 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, Fractures, pyelonephritis (Diabetes mellitus)</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>PT. fell in Home of Relatives Down Basement Steps</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>12 30</u> 8-26-58 p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Takoma Park, Montgomery, Md</u> (County) (State)	
21. I certify that I attended the deceased from <u>8-26-58</u> , 19 <u>58</u> , to <u>9-10-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-9-58</u> , 19 <u>58</u> , and that death occurred at <u>8:25</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave S Takoma Park, Md</u> DATE SIGNED <u>9-10-58</u>	
ACTUAL SIGNATURE <u>Recharl H. Clapp</u> M.D.		DATE <u>SEP 15 '58</u>	
PHYSICIAN'S NAME (Type) <u>Takoma Park, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-12-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LONG ISLAND CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>N.Y. NY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. Hawkes Sons, Inc.</u> ADDRESS <u>1786 Pa. Ave. NW</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

CERTIFICATE OF DEATH

WILLIAM RICHARD

IN DEATH

1900

10346

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 47 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1904 Graham Avenue			
3. NAME OF DECEASED (Type or print) First Thomas Middle Michael Last Geiger				4. DATE OF DEATH Month September Day 17 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 14, 1949	
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Thomas L. Geiger				14. MOTHER'S MAIDEN NAME Helen Dashko			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphocytic Leukemia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 days 10 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1, 1958 to September 17, 1958 that I last saw the deceased alive on September 17, 1958 and that death occurred at 10:00 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Nathan S. Taylor				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9-17-58			
PHYSICIAN'S NAME (Type) N Nathan S. Taylor, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 20, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Roman Catholic		22d. LOCATION (City, town, or county) (State) Windber, Somerset Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Meek				ADDRESS Windber, Penna.		24a. REC'D BY REGISTRAR DATE SEP 22 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kious			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Labour, Penna.

St. Mary's Parish Catholic Windsor, Somerset Co. Pa.

1-322346

10347

CERTIFICATE OF DEATH

10314

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>7807-Bickyard Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel J. Goldberg</u>				4. DATE OF DEATH Month Day Year <u>Sept. 27 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jul-27-1920</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Anesthetic technician</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Albany, N. Y. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Harry Goldberg</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Moskowitz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or date of service) <u>World War II</u>				16. SOCIAL SECURITY NO. <u>151-15-10000</u>			
17. INFORMANT <u>Morton Goldberg</u>				Address <u>1510 Falls Church Rd. Falls Church, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ischemic myocarditis</u> DUE TO (c) <u>Acute Rheumatic pericarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10 days</u> <u>2 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/20/1958</u> to <u>9/27/1958</u> , that I last saw the deceased alive on <u>9/27/1958</u> , and that death occurred at <u>4:25 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph N. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>9/27/58</u>			
PHYSICIAN'S NAME (Type) <u>HOPKINS N. JONES</u>				<u>ROCKVILLE, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA0</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawyers Son</u> ADDRESS <u>Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kenna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10315

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. LENGTH OF STAY IN 1b Found dead		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Norwood Rd				d. STREET ADDRESS 13210 Georgia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maiben Ernest Gordon				4. DATE OF DEATH Month Sept. Day 26, Year 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/14	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant, Ass't. Mgr.				10b. KIND OF BUSINESS OR INDUSTRY Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Gordon				14. MOTHER'S MAIDEN NAME Christine Mills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW #2 579-05-7005		17. INFORMANT Laurese Byrd Gordon		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9731 DUE TO Carbon monoxide poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH Found dead in auto.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Body badly decomposed. Apparently dead for about 2 wks. when found						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Nose attached from exhaust extending into car					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/26/58			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/58		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'l. Cemetery		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR SEP 30 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Huns			

10322

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
EDUCATION: [illegible]
MARRIAGE: [illegible]
RELIGION: [illegible]
PREVIOUS ILLNESS: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

10322

10322

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10349

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) <u>UPTON</u> <u>EUGENE</u> <u>GRANT</u>		4. DATE OF DEATH <u>September 3</u> 19 <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1930</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR <u>9</u> Months <u>10</u> Days	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Grant</u>		14. MOTHER'S MAIDEN NAME <u>Bessie McKilvey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>Marines</u>		16. SOCIAL SECURITY NO. <u>573-34-9915</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> 910.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Rupture Rt. pulmonary artery</u> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pushing fallen tree (with bulldozer) which snapped back and hit him.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>9-3-58</u> Hour <u>8</u> a. m. <u>pm</u>		20d. INJURY OCCURRED <u>While at work</u> <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Parkland Hill Rd</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>SEP 5 '58</u> DATE	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6234 9/26/58 rggj

10317

10297
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Chicago, Ill. 51X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverly Sanitarium		d. STREET ADDRESS 850 Lake Shore Rd. Rockville Pike	
3. NAME OF DECEASED (Type or print) WILLIAM First HENRY Middle GREENLEAF Last		4. DATE OF DEATH Month 9 Day 14 Year 1958 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 15, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer (retired)		10b. KIND OF BUSINESS OR INDUSTRY Mass.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Greenleaf		14. MOTHER'S MAIDEN NAME -----Lane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes Sp.Am. War.		16. SOCIAL SECURITY NO. 340-10-0532	
17. INFORMANT (daughter) Virginia Greenough		Address Wash., D. C. 5020 Palisade Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 10 YRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARKINSON'S DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 5, 1958 to Sep 14, 1958 , that I last saw the deceased alive on Sep 13, 1958 , and that death occurred at 3:42 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1835 Eye St NW Washington DC DATE SIGNED Sep 14, 1958			
ACTUAL SIGNATURE Hill Carter		M.D. 1835 Eye St NW	
PHYSICIAN'S NAME (Type) HILL CARTER		Washington DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-15-1958	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Saviers Sons		24a. REC'D BY REGISTRAR Washington, D. C.	
24b. REGISTRAR'S SIGNATURE Carlton L. Huns		DATE SEP 16 '58	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10350

CERTIFICATE OF DEATH

Reg. Dist. No.

10318

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>15 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>117 UNIVERSITY BLVD. WEST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR CECIL GRETTON</u>				4. DATE OF DEATH Month Day Year <u>SEPT. 27 1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 21, 1878</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COMMERCIAL ARTIST.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>ENGLAND.</u>		12. CITIZEN OF WHAT COUNTRY? <u>ENGLAND.</u> ✓	
13. FATHER'S NAME <u>HENRY GRETTON</u>				14. MOTHER'S MAIDEN NAME <u>WACE.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>037-01-7305</u>		17. INFORMANT <u>WENEC. GRETTON</u>		Address <u>AS ABOVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY OCCLUSION</u> DUE TO (b) <u>CORONARY ATHEROSCLEROSIS.</u> DUE TO (c) <u>GENERAL ATHEROSCLEROSIS.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES.</u> <u>YEARS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC AURICULAR FIBRILLATION. - CARDIOMEGALY.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>NOV. 1957</u> , to <u>SEPT. 27, 1958</u> , that I last saw the deceased alive on <u>SEPT. 27, 1958</u> , and that death occurred at <u>9:55 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James A. Roberts</u>				ADDRESS (Street, city or town, state) <u>M.D. 8907 GEORGIA AVENUE</u>		DATE SIGNED <u>SEPT 27, 1958</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>				<u>SILVER SPRING, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>9/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jaska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE SEP 29 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10351

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>this question not answered</u>				d. STREET ADDRESS <u>19536 E. Beekhill</u>			
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>L. GRISAMORE</u> Last <u>GRISAMORE</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3 '94</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng. R.R. Rd.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas GRISAMORE</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWII</u>				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Nelson GRISAMORE</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Cardiac Standstill</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>Sept. 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 17</u> , 19 <u>58</u> , and that death occurred at <u>6 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Milton Gysack</u>				ADDRESS (Street, city or town, state) <u>1302 - 15th N.W., Wash. D.C.</u> DATE SIGNED <u>9/17/58</u>			
PHYSICIAN'S NAME (Type) <u>Milton Gysack</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian</u>	22d. LOCATION (City, town, or county) <u>Alexandria, Virginia</u>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Mountcastle</u> ADDRESS <u>Box 65 Alexandria, Va.</u>				24a. REC'D BY REGISTRAR <u>SEP 22 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1921</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. DISEASE OR INJURY <i>Coronary Artery Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		11. SIGNATURE OF WITNESS <i>John J. Smith</i>		12. SIGNATURE OF DECEASED <i>John J. Smith</i>	
13. SIGNATURE OF REGISTRAR <i>J. H. Smith</i>		14. SIGNATURE OF CLERK <i>J. H. Smith</i>		15. SIGNATURE OF JURY <i>J. H. Smith</i>	
16. SIGNATURE OF JURY <i>J. H. Smith</i>		17. SIGNATURE OF JURY <i>J. H. Smith</i>		18. SIGNATURE OF JURY <i>J. H. Smith</i>	
19. SIGNATURE OF JURY <i>J. H. Smith</i>		20. SIGNATURE OF JURY <i>J. H. Smith</i>		21. SIGNATURE OF JURY <i>J. H. Smith</i>	
22. SIGNATURE OF JURY <i>J. H. Smith</i>		23. SIGNATURE OF JURY <i>J. H. Smith</i>		24. SIGNATURE OF JURY <i>J. H. Smith</i>	
25. SIGNATURE OF JURY <i>J. H. Smith</i>		26. SIGNATURE OF JURY <i>J. H. Smith</i>		27. SIGNATURE OF JURY <i>J. H. Smith</i>	
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31. SIGNATURE OF JURY <i>J. H. Smith</i>		32. SIGNATURE OF JURY <i>J. H. Smith</i>		33. SIGNATURE OF JURY <i>J. H. Smith</i>	
34. SIGNATURE OF JURY <i>J. H. Smith</i>		35. SIGNATURE OF JURY <i>J. H. Smith</i>		36. SIGNATURE OF JURY <i>J. H. Smith</i>	
37. SIGNATURE OF JURY <i>J. H. Smith</i>		38. SIGNATURE OF JURY <i>J. H. Smith</i>		39. SIGNATURE OF JURY <i>J. H. Smith</i>	
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43. SIGNATURE OF JURY <i>J. H. Smith</i>		44. SIGNATURE OF JURY <i>J. H. Smith</i>		45. SIGNATURE OF JURY <i>J. H. Smith</i>	
46. SIGNATURE OF JURY <i>J. H. Smith</i>		47. SIGNATURE OF JURY <i>J. H. Smith</i>		48. SIGNATURE OF JURY <i>J. H. Smith</i>	
49. SIGNATURE OF JURY <i>J. H. Smith</i>		50. SIGNATURE OF JURY <i>J. H. Smith</i>		51. SIGNATURE OF JURY <i>J. H. Smith</i>	
52. SIGNATURE OF JURY <i>J. H. Smith</i>		53. SIGNATURE OF JURY <i>J. H. Smith</i>		54. SIGNATURE OF JURY <i>J. H. Smith</i>	
55. SIGNATURE OF JURY <i>J. H. Smith</i>		56. SIGNATURE OF JURY <i>J. H. Smith</i>		57. SIGNATURE OF JURY <i>J. H. Smith</i>	
58. SIGNATURE OF JURY <i>J. H. Smith</i>		59. SIGNATURE OF JURY <i>J. H. Smith</i>		60. SIGNATURE OF JURY <i>J. H. Smith</i>	
61. SIGNATURE OF JURY <i>J. H. Smith</i>		62. SIGNATURE OF JURY <i>J. H. Smith</i>		63. SIGNATURE OF JURY <i>J. H. Smith</i>	
64. SIGNATURE OF JURY <i>J. H. Smith</i>		65. SIGNATURE OF JURY <i>J. H. Smith</i>		66. SIGNATURE OF JURY <i>J. H. Smith</i>	
67. SIGNATURE OF JURY <i>J. H. Smith</i>		68. SIGNATURE OF JURY <i>J. H. Smith</i>		69. SIGNATURE OF JURY <i>J. H. Smith</i>	
70. SIGNATURE OF JURY <i>J. H. Smith</i>		71. SIGNATURE OF JURY <i>J. H. Smith</i>		72. SIGNATURE OF JURY <i>J. H. Smith</i>	
73. SIGNATURE OF JURY <i>J. H. Smith</i>		74. SIGNATURE OF JURY <i>J. H. Smith</i>		75. SIGNATURE OF JURY <i>J. H. Smith</i>	
76. SIGNATURE OF JURY <i>J. H. Smith</i>		77. SIGNATURE OF JURY <i>J. H. Smith</i>		78. SIGNATURE OF JURY <i>J. H. Smith</i>	
79. SIGNATURE OF JURY <i>J. H. Smith</i>		80. SIGNATURE OF JURY <i>J. H. Smith</i>		81. SIGNATURE OF JURY <i>J. H. Smith</i>	
82. SIGNATURE OF JURY <i>J. H. Smith</i>		83. SIGNATURE OF JURY <i>J. H. Smith</i>		84. SIGNATURE OF JURY <i>J. H. Smith</i>	
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88. SIGNATURE OF JURY <i>J. H. Smith</i>		89. SIGNATURE OF JURY <i>J. H. Smith</i>		90. SIGNATURE OF JURY <i>J. H. Smith</i>	
91. SIGNATURE OF JURY <i>J. H. Smith</i>		92. SIGNATURE OF JURY <i>J. H. Smith</i>		93. SIGNATURE OF JURY <i>J. H. Smith</i>	
94. SIGNATURE OF JURY <i>J. H. Smith</i>		95. SIGNATURE OF JURY <i>J. H. Smith</i>		96. SIGNATURE OF JURY <i>J. H. Smith</i>	
97. SIGNATURE OF JURY <i>J. H. Smith</i>		98. SIGNATURE OF JURY <i>J. H. Smith</i>		99. SIGNATURE OF JURY <i>J. H. Smith</i>	
100. SIGNATURE OF JURY <i>J. H. Smith</i>		101. SIGNATURE OF JURY <i>J. H. Smith</i>		102. SIGNATURE OF JURY <i>J. H. Smith</i>	

RECEIVED JAN 15 1921
BALTIMORE, MD.

10278 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Wash. Sanitarium + Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Gerard Groesbeck</u>				4. DATE OF DEATH Month Day Year <u>Sept. 10 1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/74</u>	9. AGE (In years last birthday) <u>84</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Herman J. Groesbeck</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Perry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>WW Navy None</u>		17. INFORMANT Address <u>med. records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>293X Congestive Cardiac Failure</u> DUE TO (b) <u>Broncho-pneumonia</u> DUE TO (c) <u>Anemia - Secondary Severe</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>1 week</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X Bleeding of Bowel-Large.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-18-</u> , 19 <u>58</u> , to <u>9-10-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-10-</u> , 19 <u>58</u> , and that death occurred at <u>8 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>		M.D. <u>Takoma Park, Md.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>9/10/58</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Conrad E. Hume</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. PLACE OF BIRTH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH	
16. CAUSE OF DEATH		17. MANNER OF DEATH		18. PLACE OF BIRTH	
19. DATE OF BIRTH		20. SEX OF BIRTH		21. PLACE OF BIRTH	
22. DATE OF DEATH		23. TIME OF DEATH		24. PLACE OF DEATH	
25. CAUSE OF DEATH		26. MANNER OF DEATH		27. PLACE OF BIRTH	
28. DATE OF BIRTH		29. SEX OF BIRTH		30. PLACE OF BIRTH	
31. DATE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH	
34. CAUSE OF DEATH		35. MANNER OF DEATH		36. PLACE OF BIRTH	
37. DATE OF BIRTH		38. SEX OF BIRTH		39. PLACE OF BIRTH	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. DATE OF BIRTH		47. SEX OF BIRTH		48. PLACE OF BIRTH	
49. DATE OF DEATH		50. TIME OF DEATH		51. PLACE OF DEATH	
52. CAUSE OF DEATH		53. MANNER OF DEATH		54. PLACE OF BIRTH	
55. DATE OF BIRTH		56. SEX OF BIRTH		57. PLACE OF BIRTH	
58. DATE OF DEATH		59. TIME OF DEATH		60. PLACE OF DEATH	
61. CAUSE OF DEATH		62. MANNER OF DEATH		63. PLACE OF BIRTH	
64. DATE OF BIRTH		65. SEX OF BIRTH		66. PLACE OF BIRTH	
67. DATE OF DEATH		68. TIME OF DEATH		69. PLACE OF DEATH	
70. CAUSE OF DEATH		71. MANNER OF DEATH		72. PLACE OF BIRTH	
73. DATE OF BIRTH		74. SEX OF BIRTH		75. PLACE OF BIRTH	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. DATE OF BIRTH		83. SEX OF BIRTH		84. PLACE OF BIRTH	
85. DATE OF DEATH		86. TIME OF DEATH		87. PLACE OF DEATH	
88. CAUSE OF DEATH		89. MANNER OF DEATH		90. PLACE OF BIRTH	
91. DATE OF BIRTH		92. SEX OF BIRTH		93. PLACE OF BIRTH	
94. DATE OF DEATH		95. TIME OF DEATH		96. PLACE OF DEATH	
97. CAUSE OF DEATH		98. MANNER OF DEATH		99. PLACE OF BIRTH	
100. DATE OF BIRTH		101. SEX OF BIRTH		102. PLACE OF BIRTH	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10279
CERTIFICATE OF DEATH

Reg. Dist. No. 10321

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN IB <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium</u>		e. STREET ADDRESS <u>17417 Carroll Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>ANN</u> Last <u>GROSSMAN</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Jewish</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/82</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>Theodore Brown</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Gladstone</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>years?</u> <u>years?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>Sept 2</u> , 1958, that I last saw the deceased alive on <u>Sept 1</u> , 1958, and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave, Tak. Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. HARE</u>		DATE SIGNED <u>9/2/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/3-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nat Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gledberg Funeral Home</u>		ADDRESS <u>4217 9th St NW</u>	
24a. REC'D BY REGISTRAR <u>SEP 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15, 1925*

5. Place of death: *Home*

6. Cause of death: *Heart disease*

7. Duration of illness: *2 weeks*

8. Name of physician: *Dr. J. Smith*

9. Name of funeral director: *Mr. J. Brown*

10. Name of informant: *John Doe*

11. Address of informant: *123 Main St, Baltimore, Md.*

12. Signature of informant: *[Signature]*

13. Signature of physician: *[Signature]*

14. Signature of funeral director: *[Signature]*

15. Signature of informant: *[Signature]*



RECEIVED
JAN 16 1925
BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10352

CERTIFICATE OF DEATH

Reg. Dist. No.

10322

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 98 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Louisiana b. COUNTY Orleans c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Orleans d. STREET ADDRESS 2732 Dreux Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William (none) Gunn, Jr.		4. DATE OF DEATH Month Day Year September 8, 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 2, 1889
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Supply Clerk	11. BIRTHPLACE (State or foreign country) Louisiana
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Gunn, Sr.	
14. MOTHER'S MAIDEN NAME Margaret Annie McGary		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pharynx 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 2, 19 58 to September 8, 19 58 , that I last saw the deceased alive on September 8, 19 58 , and that death occurred at 5:31 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland DATE SIGNED 9/8/58 ACTUAL SIGNATURE G. Richard Lee M.D. PHYSICIAN'S NAME (Type) G. RICHARD LEE, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	22b. DATE THEREOF 9/9/58	22c. NAME OF CEMETERY OR CREMATORY Meterie Cemetery	22d. LOCATION (City, town, or county) (State) Orleans Parish, New Orleans
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR Bethesda, Maryland 24b. REGISTRAR'S SIGNATURE Arthur S. Harris L.A.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, and 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	

10353

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 75 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mickey Middle Sue Last Hale		4. DATE OF DEATH Month September Day 29 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 3, 1939
9. AGE (In years last birthday) 18 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Cook		14. MOTHER'S MAIDEN NAME Ila Nelle Carroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic shock 648.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Choriocarcinoma destruens DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Minutes Months
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1958 , to September 29, 1958 , that I last saw the deceased alive on September 29, 1958 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack Levin		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/29/58	
PHYSICIAN'S NAME (Type) JACK LEVIN, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 10/2/58	
22c. NAME OF CEMETERY OR CREMATORY Lake Side Cemetery		22d. LOCATION (City, town, or county) (State) Stamps, Arkansas	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR OCT 2 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>E.</u> Last <u>Hanson</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		11. BIRTHPLACE (State or foreign country) <u>Evanston Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles J. Hanson</u>				14. MOTHER'S MAIDEN NAME <u>Emma Charlotta Peterson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Clara V. Hanson</u>		17. INFORMANT <u>Sae</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLUS</u> <u>527.1</u> DUE TO <u>AURICULAR</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE & FIBRILLATION</u> DUE TO (c) <u>EMPHYSEMA, PULMONARY</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>5 YEARS</u> <u>10 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8-12</u> , 19 <u>58</u> , to <u>12:40 9-10 19 58</u> that I last saw the deceased alive on <u>9-9</u> , 19 <u>58</u> , and that death occurred at <u>12:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Philip R. James</u> M.D. <u>WASHINGTON CLINIC, D.C.</u> <u>9-10-58</u>							
ACTUAL SIGNATURE <u>Philip R. James</u>							
PHYSICIAN'S NAME (Type) <u>PHILIP R. JAMES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9/12/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.,</u>				24a. REC'D BY REGISTRAR <u>SEP 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 19

1900

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		1900		BOSTON	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
100 N. BOSTON ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		1900		BOSTON	
FATHER		MOTHER		BIRTH		EDUCATION		RELIGION		MARRIAGE	
JAMES J. JONES		MARY J. JONES		1855		COMMON SCHOOLS		METHODIST		1875	
BORN		DIED		AGE		SEX		RACE		DATE OF DEATH	
1855		1900		45		M		W		1900	
FATHER		MOTHER		BIRTH		EDUCATION		RELIGION		MARRIAGE	
JAMES J. JONES		MARY J. JONES		1855		COMMON SCHOOLS		METHODIST		1875	
BORN		DIED		AGE		SEX		RACE		DATE OF DEATH	
1855		1900		45		M		W		1900	

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10355

CERTIFICATE OF DEATH

10325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN		c. LENGTH OF STAY IN 1b 1 mo. 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARYLANDER REST HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JESSE Middle IRVIN Last HARR		4. DATE OF DEATH Month SEPT. Day 26 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/23/80
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe salesman self-employed		10b. KIND OF BUSINESS OR INDUSTRY Shoe	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JESSE M. HARR	
14. MOTHER'S MAIDEN NAME ANNIE E. WOOD		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Miss Edith M. Harr, 9516 St. Andrews Way Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 Day 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from Sept. 15, 1958 to Sept. 26, 1958 , that I last saw the deceased alive on Sept. 25, 1958 , and that death occurred at 7:40 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE James P. Kerr M.D. Damascus, Md.		DATE SIGNED 9/26/58	
PHYSICIAN'S NAME (Type) JAMES P. KERR			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/27/58	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond H. Zucka		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE SEP 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10280

CERTIFICATE OF DEATH

10326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>59 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7110 Poplar Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>IRENE</u> Last <u>HARRIES</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 28, 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Richard T. Humphrey</u>				14. MOTHER'S MAIDEN NAME <u>Ada Connors</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mr. Marion J. Yates, 629 Dist Ave. S.S.Md.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile Arteriosclerosis</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Apr.</u> 19 <u>46</u> , to <u>3 Sept</u> 19 <u>58</u> , that I last saw the deceased alive on <u>25 Aug</u> 19 <u>58</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7112 Willow Ave. Takoma Park, Md.</u> DATE SIGNED <u>3 Sept 1958</u>							
ACTUAL SIGNATURE <u>H. B. Queen</u>				PHYSICIAN'S NAME (Type) <u>H. B. Queen</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Sept. 5, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Carroll St. N.W. D.C.</u>				24a. REC'D BY REGISTRAR <u>SEP 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be released by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 7, Film G234, 10/9/58
CERTIFICATE OF DEATH

10327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring 56</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Garden Nursery Home</i>		d. STREET ADDRESS <i>10411 Hayes Ave.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Alta Fay Hattery</i>		4. DATE OF DEATH Month Day Year <i>Sept. 23 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>25 March 1892</i>
9. AGE (In years last birthday) <i>66 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Stephen Stephenson</i>		14. MOTHER'S MAIDEN NAME <i>SARAH ALTA Lee</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Louise Hattery</i>		Address <i>10411 Hayes Ave, Sil. Sprg., Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Vascular accident Cerebral arteriosclerosis</i> DUE TO <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Progressive arteriosclerosis</i> DUE TO <i>15 yrs</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>20 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1952</i> , to <i>23 Sept, 1958</i> , that I last saw the deceased alive on <i>23 Sept, 1958</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Martin L. White</i>		ADDRESS (Street, city or town, state) <i>11134 Georgia Ave Silver Spring Md 20901</i>	
DATE SIGNED <i>9/23/58</i>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>9/26/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>WOODLAND CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>VAN WERT, OHIO</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Death Funeral Home</i>		ADDRESS <i>4812 9th Ave.</i>	
24a. REC'D BY REGISTRAR <i>DOET 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10357

CERTIFICATE OF DEATH

Reg. Dist. No.

10328

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2708 FINCH STREET		d. STREET ADDRESS 1 2708 FINCH STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle THERESA Last HAWKINS		4. DATE OF DEATH Month SEPT. Day 3 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/29/74
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK B. KAUS		14. MOTHER'S MAIDEN NAME JULIA WHALEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Paul E. Hawkins, 2708 Finch St.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO HYPERTENSION, ARTERIAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 20 YRS. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, GENERALIZED INTERVAL BETWEEN ONSET AND DEATH 2 HRS.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1957 to 3 SEPT. 1958 , that I last saw the deceased alive on 3 SEPT. 1958 , and that death occurred at 3 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE LBSnow		ADDRESS (Street, city or town, state) 9013 FLOWER AVE DATE SIGNED 9/4/58	
PHYSICIAN'S NAME (Type) L. B. SNOW		SILVER SPRING, MD	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/5/58	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR SEP 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

<p>1. NAME OF DECEASED <i>James Thomas</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>38</i></p>		<p>4. DATE OF BIRTH <i>Aug 15 1895</i></p>	
<p>5. PLACE OF BIRTH <i>Massachusetts</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. PLACE OF DEATH <i>Home</i></p>	
<p>9. DATE OF DEATH <i>Oct 10 1933</i></p>		<p>10. TIME OF DEATH <i>10:30 AM</i></p>	
<p>11. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>12. SIGNATURE OF REGISTRAR <i>John Doe</i></p>	
<p>13. SIGNATURE OF DECEASED <i>James Thomas</i></p>		<p>14. SIGNATURE OF WITNESSES <i>John Doe, Jane Smith</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10329

Reg. Dist. No.

10358

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 4001 8th Street, S.E.	
3. NAME OF DECEASED (Type or print) First Gerald Middle Jameson Last Hayden		4. DATE OF DEATH Month September Day 14 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 December 1942
9. AGE (In years last birthday) yrs. 15		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leo Hayden		14. MOTHER'S MAIDEN NAME Mary V. Jameson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency DUE TO 197.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Widespread pulmonary metastases 2 mos. (c) Rhabdomyosarcoma, lt chest wall 9 mos.		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 23 , 19 58 , to September 14 , 19 58 , that I last saw the deceased alive on September 14 , 19 58 , and that death occurred at 10:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/15/58			
ACTUAL SIGNATURE Harold R. Silberman M.D.		NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Harold R. Silberman, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-17-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers, Inc.		ADDRESS 517-11 St. S.E.	
24a. REC'D BY REGISTRAR SEP 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, OCT. 1918

NAME OF DECEASED CAROL ANN ALLEN		SEX FEMALE		AGE 22 years		DATE OF BIRTH OCTOBER 1, 1896		PLACE OF BIRTH BOSTON, MASS.		PLACE OF DEATH BOSTON, MASS.	
OCCUPATION None		MARITAL STATUS Single		CAUSE OF DEATH Influenza		PERIOD OF ILLNESS 2 days		PLACE OF INTERMENT Mount Hope Cemetery		DATE OF INTERMENT OCTOBER 1, 1918	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF REGISTRAR (None)		SIGNATURE OF JUDGE (None)	
CITY BOSTON		COUNTY SUFFOLK		STATE MASSACHUSETTS		YEAR 1918		MONTH OCTOBER		DAY 1	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, OCT. 1918

10359

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Georgia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Covington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 824 Monticello			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charlie Middle Morriel Last HEAD				4. DATE OF DEATH Month September Day 14 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 October 1937		9. AGE (In years last birthday) yrs. 20	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charlie Manuel HEAD				14. MOTHER'S MAIDEN NAME Ophelia STAPP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, Currently		16. SOCIAL SECURITY NO. 254 50 5034		17. INFORMANT Address (Wife) Mrs. Sharon Lucille HEAD (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, diffuse 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) primary site unknown DUE TO (c) 3 WKS						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? " YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Sept. , 19 58 , to 14 Sept. , 19 58 , that I last saw the deceased alive on 14 Sept. , 19 58 , and that death occurred at 3:05 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Galbraith Jr				ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-15-58			
PHYSICIAN'S NAME (Type) Robert G. Galbraith, Jr. LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-58		22c. NAME OF CEMETERY OR CREMATORY Lawnwood Cemetery		22d. LOCATION (City, town, or county) (State) Covington, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 1400 Chapin St. Washington, D.C.				24a. REC'D BY REGISTRAR SEP 16 '58		24b. REGISTRAR'S SIGNATURE Conner L. Harris	

1 **8**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH - BATHING

Name of Deceased (Print Name)		Date of Birth	
Sex		Race	
Usual Residence		Date of Death	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Signature		Date of Signature	
Signature of Medical Examiner		Signature of Coroner	
Date of Signature		Date of Signature	
Signature of Health Officer		Signature of Registrar	
Date of Signature		Date of Signature	

CERTIFICATE OF DEATH

Reg. Dist. No.

10360

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5525 Prospect Street</u>		d. STREET ADDRESS <u>5525 Prospect Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EVELYN</u> Middle <u>A.</u> Last <u>HEARN</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/20/1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>20</u>	
11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Archie H Asquith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rutherford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wilfred Hearn-husband-same as item #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>8 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1949</u> , to <u>9-10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-9</u> , 19 <u>58</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew G. Preindoni</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1150 Conn Ave NW Wash DC</u> <u>9/10/58</u>	
PHYSICIAN'S NAME (Type) <u>Andrew G. Preindoni</u>		<u>1150 Conn. Ave. N. W. Wash. 6, D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edgehill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Charlestown, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10332

10361

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29, 3V01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 4904 Stafford Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Harry Last Hilgeman		4. DATE OF DEATH Month September Day 21 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Chief		10b. KIND OF BUSINESS OR INDUSTRY Fire fighting	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick G. Hilgeman		14. MOTHER'S MAIDEN NAME Mary Huiss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-28-8222	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUB-DURAL HEMORRHAGE, PULM. EDEMA. DUE TO CARCINOMA OF MAXILLARY ANTRUM & LOCAL EXTENSION TO SKULL, & GENERALIZED METASTASES. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 13, 19 58 , to September 21 19 58 , that I last saw the deceased alive on September 21 19 58 , and that death occurred at 7:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/22/58 ACTUAL SIGNATURE Marvin Romsdahl M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Marvin Romsdahl, M. D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/25/58	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave. ADDRESS		24a. REC'D BY REGISTRAR SEP 25 '58 DATE	24b. REGISTRAR'S SIGNATURE James S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10333

10362

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>805 Heron Drive</u>		d. STREET ADDRESS <u>1805 Heron Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles F. Hoffman Jr</u> First Middle Last		4. DATE OF DEATH <u>9-10-1958</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-17-1891</u> 9. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY YARD</u>	11. BIRTHPLACE (State or foreign country) <u>WASH. DC.</u>
13. FATHER'S NAME <u>CHARLES F HOFFMAN SR</u>		14. MOTHER'S MAIDEN NAME <u>LAURA STEWART</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DOROTHY YOUNG</u> Address <u>805 HERON SIL SPRG MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsons Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>10 yrs. &</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>15 July</u> , 1958, to <u>10 Sept</u> , 1958, that I last saw the deceased alive on <u>9 Sept</u> , 1958, and that death occurred at <u>9:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. B. Queen</u> M.D.		ADDRESS (Street, city or town, state) <u>7112 Willow Ave</u> DATE SIGNED <u>10 Sept 1958</u>	
PHYSICIAN'S NAME (Type) <u>A. B. QUEEN</u>		TAKOMA PARK, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCKVILLE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ROCKVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS CO</u> ADDRESS <u>1400 CHAPIN ST</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

CERTIFICATE OF DEATH

1933

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Date of registration</p>		<p>12. Place of registration</p>	

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10363

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 26 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Waymond Middle Everett Last HOLLAND			4. DATE OF DEATH Month September Day 26 Year 1958		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-97		9. AGE (In years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S.Gov't.	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William HOLLAND			14. MOTHER'S MAIDEN NAME Dora M. STORLTZ		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 577-09-9036	17. INFORMANT Wife, Gertrude Holland, 1306 Euclid St., NW		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic carcinoma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 mo. appr. unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Washington, D.C.	(County) D.C.	(State) D.C.
21. I certify that I attended the deceased from Sept. 1 , 19 58 , to Sept. 26 , 19 58 , that I last saw the deceased alive on Sept. 25 , 19 58 , and that death occurred at 6:40 A.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Jerome A. Gold		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC		DATE SIGNED 9-27-58	
PHYSICIAN'S NAME (Type) Jerome A. Gold, LT, MC, USN Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-3-58	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis, 1432 U Street, N.W., Washington, D.C.			24a. REC'D BY REGISTRAR SEP 30 '58	24b. REGISTRAR'S SIGNATURE Carlton S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10281

CERTIFICATE OF DEATH

10335

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY P. D.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 67 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First L. Middle A. Last Horton				4. DATE OF DEATH Month 9 - Day 17 - Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-4-'93	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instrument Maker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Horton				14. MOTHER'S MAIDEN NAME Martha Duvall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Washington Sanitarium & Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Left Cerebellar Hemorrhage 3-4 hours 297X DUE TO Left Subdural Hemorrhage 3-4 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X DUE TO Agranulocytosis & Thrombocytopenia 2 1/2 mos. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Left Hemothorax, Subacute Bacterial Endocarditis, Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December, 1955 , to Sept. 17, 1958 , that I last saw the deceased alive on Sept. 16, 1958 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Russell B. Arnold M.D. 8801 Coleridge Road							
PHYSICIAN'S NAME (Type) Russell B. Arnold M.D., Silver Spring, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 19-1958		22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) (State) Falls Church, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St NW DC				24a. REC'D BY REGISTRAR SEP 19 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Travis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10364

CERTIFICATE OF DEATH

Reg. Dist. No.

10336

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 2963 Tilden Street, N.W.			
3. NAME OF DECEASED (Type or print) First William Middle R Last Houchen				4. DATE OF DEATH Month September Day 5 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 8, 1872		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) INDIANA		
13. FATHER'S NAME JOHN LEWIS HOUCHEN				14. MOTHER'S MAIDEN NAME AMANDA TANNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mary Rose Houchen, 2963 Tilden St. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intermittent DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-25 , 19 58 , to 9-5 , 19 58 , that I last saw the deceased alive on 9-5 , 19 58 , and that death occurred at 11:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5000 Kansas Rd NW 9-6-58							
ACTUAL SIGNATURE Wm. Fleet Luckett				M.D. 5000 Kansas Rd NW			
PHYSICIAN'S NAME (Type) Wm. Fleet Luckett							
22a. BURIAL, CREMATION, or other disposition of body cremation		22b. DATE THEREOF 9/8/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Thomas Co.				24a. REC'D BY REGISTRAR SEP 8 '58		24b. REGISTRAR'S SIGNATURE Charles S. Thomas	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10337

10365

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Colonial Beach</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colonial Beach</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp</u>		d. STREET ADDRESS <u>83x3</u>	
3. NAME OF DECEASED (Type or print) <u>Mellie T. Hoy</u>		4. DATE OF DEATH <u>Sept 10 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt Worker</u>	
11. BIRTHPLACE (State or foreign country) <u>Silver Sp - Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Ryan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Devaney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Donald Watson</u>		Address <u>9917 Edgewood Rd Bethesda - Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis -</u> (c) <u>Chronic Nephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1, 1956</u> to <u>Sept 10, 1958</u> , that I last saw the deceased alive on <u>9/10/58</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u>	
M.D. <u>[Signature]</u>		DATE SIGNED <u>9/10/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. J. W. Bird</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-12-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Margaret Collins</u>		ADDRESS <u>3821-14th St. N.W. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>SEP 15 '58</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>De</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>708 Phila. Ave. Cur-Lu Nursing Home</u>		d. STREET ADDRESS <u>807-10 St. N.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>EMILY</u> Middle <u>B.</u> Last <u>HUGHES</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 20, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>yes U.S.</u>		13. FATHER'S NAME <u>ARCHIBALD BURGESS</u>	
14. MOTHER'S MAIDEN NAME <u>SARAH H. TURPIN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Catherine A. Franks - Leelandton Md</u> Address <u>McKay Beach</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decomposition</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>9.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 <u>57</u> to <u>6-1st</u> 19 <u>58</u> , that I last saw the deceased alive on <u>5-8-58</u> , 19 <u>58</u> , and that death occurred at <u>5:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Glend</u> M.D.		ADDRESS (Street, city or town, state) <u>9016 Glenwood Rd</u> DATE SIGNED <u>9/16/58</u>	
PHYSICIAN'S NAME (Type) <u>John H. H. H.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-9-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Leebens</u> ADDRESS <u>WASH. D.C.</u>		24a. REC'D BY REGISTRAR <u>SEP 8 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Hand
No

<p>1. Name of Deceased: <i>John D. Smith</i></p>	
<p>2. Date of Death: <i>Jan 15 1902</i></p>	
<p>3. Place of Death: <i>Home</i></p>	
<p>4. Cause of Death: <i>Heart Disease</i></p>	
<p>5. Age: <i>65</i></p>	
<p>6. Sex: <i>Male</i></p>	
<p>7. Occupation: <i>Teacher</i></p>	
<p>8. Signature of Physician: <i>John D. Smith</i></p>	
<p>9. Signature of Registrar: <i>John D. Smith</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10366

CERTIFICATE OF DEATH

Reg. Dist. No. 10339

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 472-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1918-18th St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle Last <u>Hughes</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22 1890</u> 68 yrs.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Andrew Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Lottie BEALER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angerline Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/3</u> , 19 <u>58</u> , to <u>9/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/7</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1835 Eye St N.W.</u> DATE SIGNED <u>9/8/58</u> ACTUAL SIGNATURE <u>Alvin E. Kay</u> M.D. PHYSICIAN'S NAME (Type) <u>ALVIN E. KAY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9.10.58</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Lexington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman</u> ADDRESS <u>1840-9</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10367

CERTIFICATE OF DEATH

Reg. Dist. No.

10340

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnsville</u>		d. STREET ADDRESS <u>51. Mary' Rectory</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>William</u> Last <u>Hyland</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30 1888</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md Racing Assoc</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Martin W. Hyland</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Burns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>217-07-9458</u>		17. INFORMANT <u>Martin W. Hyland, Barnsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 month</u> <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>July 11</u> , 19 <u>58</u> , to <u>Sept 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 7</u> , 19 <u>58</u> , and that death occurred at <u>9:24 P</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>John G. Fawcett</u> M.D. <u>DAWSONVILLE</u> <u>7 Sept. 58</u> PHYSICIAN'S NAME (Type) <u>JOHN G. FAWCETT</u> <u>P.O. BOYD, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Ga. Ave. Silver Spring Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Wilson, Barnsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

10368

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 18x-2	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gregory Middle Paul Last Johnson		4. DATE OF DEATH Month September Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Sept. 1958
9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Herbert JOHNSON		14. MOTHER'S MAIDEN NAME Frances D. DRAKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Herbert Johnson (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.0 Hyaline membrane disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 day DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 Sept , 19 58 , to 5 Sept. , 19 58 , that I last saw the deceased alive on 5 Sept. , 19 58 , and that death occurred at 3:15A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard A. Pearson		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-5-58	
PHYSICIAN'S NAME (Type) Howard A. Pearson, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-8-58	22c. NAME OF CEMETERY OR CREMATORY Holy Face Cemetery	22d. LOCATION (City, town, or county) (State) Leonardtown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Mattingly Funeral Home, Leonardtown, Md.		24a. REC'D BY REGISTRAR SEP 9 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051338XV4

2004

10369

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3517 Randolph Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLIE</u> Middle <u>JONES</u> Last <u>JONES</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 21, 1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>6</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent Cemetery</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Charles W. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Mary E Trunnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Carroll V Jones-son-same as 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacteremia</u> <u>602X</u> DUE TO <u>Petro Renal Abscess - Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Belateral Stenotic Renal Calculi</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks - 2 years - 15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 1955</u> , to <u>27 Sept 1958</u> , that I last saw the deceased alive on <u>27 Sept 1958</u> , and that death occurred at <u>1:56 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>615 W. Montg. Ave. Rockville, Md.</u> DATE SIGNED <u>28 Sept 58</u> ACTUAL SIGNATURE <u>W.S. Murphy</u> M.D. PHYSICIAN'S NAME (Type) <u>William S Murphy</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockveill, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>SEP 30 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10283

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, 17</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>7711 Greenwood Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Amelia Anna Kidd</u>				4. DATE OF DEATH <u>Sept. 28 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-90</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Kitchen helper-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Hood</u>				14. MOTHER'S MAIDEN NAME <u>Emma Hunt Hood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hospital Records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Cronary insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Arteriosclerosis, generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>Known</u> <u>1 year</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 1957, to <u>September 19</u> , 1958, that I last saw the deceased alive on <u>September 28</u> , 1958, and that death occurred at <u>7:40 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u>				ADDRESS (Street, city or town, state) <u>8237 Georgia Ave. Silver Spring Md.</u>			
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>				DATE SIGNED <u>Sept 29 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 3, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LINWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BRIDGEPORT BLAINE, OHIO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Traud</u>	
ADDRESS <u>254 Carroll St NW, D.C.</u>				DATE <u>OCT 1 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10370

CERTIFICATE OF DEATH

10344

Reg. Dist. No. 25

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 20 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Russell Last KINSMAN		4. DATE OF DEATH Month Sept. Day 8 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 February 1895
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Henry KINSMAN		14. MOTHER'S MAIDEN NAME Greta ISACSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I&II		16. SOCIAL SECURITY NO. 225 20 8043	
17. INFORMANT (Wife) Mrs. Amie Harper KINSMAN (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x THROMBOSIS, CEREBRAL VESSELS, MULTIPLE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS OF CEREBRAL VESSELS ? YEARS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION, SEVERE, ESSENTIAL		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 August , 19 58 , to 8 Sept. , 19 58 , that I last saw the deceased alive on 8 Sept. , 19 58 , and that death occurred at 7:45 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE F. S. Caldwell		DATE SIGNED U.S. Naval Hospital, NMMC, Bethesda, Md.	
PHYSICIAN'S NAME (Type) F.S. CALDWELL, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md. 9-8-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Hall Funeral Home, Occoquan, Virginia		24a. REC'D BY REGISTRAR 10 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. King			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10371

CERTIFICATE OF DEATH

10345

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle (nmn) Last KLAUS		4. DATE OF DEATH Month September Day 13 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 November 1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William John KLAUS		14. MOTHER'S MAIDEN NAME (First Name Unknown) HAGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I&II	
17. INFORMANT (Wife) Mrs. Arda P. KLAUS (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY OBSTRUCTION DUE TO 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA OF LUNGS DUE TO (c) SQUAMOUS CELL CARCINOMA ESOPHAGUS			
INTERVAL BETWEEN ONSET AND DEATH 48 hrs 1 YEAR 2 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 April , 19 58 , to 13 Sept. , 19 58 , that I last saw the deceased alive on 13 September , 19 58 , and that death occurred at 4:00A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE George W. Taylor Jr. M.D.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-13-58	
PHYSICIAN'S NAME (Type) George W. Taylor, Jr. CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-17-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		24a. REC'D BY REGISTRAR SEP 16 '58	
ADDRESS 1557 Wisconsin Ave. Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

MASSACHUSETTS
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
BOSTON

NAME	JOHN B. [illegible]
AGE	45
SEX	Male
RACE	White
DATE OF BIRTH	Jan. 15, 1892
PLACE OF BIRTH	[illegible]
DATE OF DEATH	Jan. 15, 1937
PLACE OF DEATH	[illegible]
Cause of Death	[illegible]
Occupation	[illegible]
Marital Status	[illegible]
Signature of Physician	[illegible]
Signature of Registrar	[illegible]

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10346

10372

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Woods, Rockville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>13004 Parkland Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Edward</u> Last <u>Kotz</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1906</u>		9. AGE (In years last birthday) <u>52</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taxicab Owner-Operator</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>America</u>
13. FATHER'S NAME <u>James Edward Kotz</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Miley</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Mrs. Regina Kotz</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>9-4-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wardensville</u>	
				22d. LOCATION (City, town, or county) (State) <u>West Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee Sons</u>		ADDRESS <u>Wash. D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10347

10284

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>1207 Spring Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sandarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Vincent James Lanza</u>		4. DATE OF DEATH <u>9-18-1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-58</u>
9. AGE (In years last birthday) <u>—</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>6</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>NAmerican</u>	
13. FATHER'S NAME <u>Vincent James Lanza Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Peterson Murphy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records - 7600 Carroll Ave Tak.Pk.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonia</u> <u>525X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broesch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROESCH, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 22, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Walters</u>		ADDRESS <u>254 Carroll St. NW. DC</u>	
24a. REC'D BY REGISTRAR <u>SEP 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Walters</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained by you. Pages 3 and 4 should be retained by the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10348
Reg. Dist. No.

10285

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK 17</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				d. STREET ADDRESS <u>710 Wabash Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Jennie</u> First <u>Lawrence</u> Middle <u>—</u> Last		4. DATE OF DEATH <u>9/26</u> Month <u>9</u> Day <u>26</u> Year <u>1958</u>					
5. SEX <u>fe</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-77</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Scott Woodring</u>				14. MOTHER'S MAIDEN NAME <u>Nancy McMullen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>old hosp. record</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>30 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>360X Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 26</u> , 19 <u>58</u> , to <u>Sept 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 26</u> , 19 <u>58</u> , and that death occurred at <u>10:14 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>Takoma Park</u>		DATE SIGNED <u>9/26/58</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 29, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEM.</u>		22d. LOCATION (City, town, or county) <u>Riggs Rd., Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Hare</u>		ADDRESS <u>254 Carroll St. NW, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll E. Hare</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF HEALTH - BATHING

10373

CERTIFICATE OF DEATH

10349

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>OLNEY</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> 26			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>				d. STREET ADDRESS <i>1003 Paul Drive</i>			
3. NAME OF DECEASED (Type or print) <i>Cora Jane Learmonth</i>				4. DATE OF DEATH <i>Sept. 21 1958</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>Cauc.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 9 1882</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Robert McClure</i>				14. MOTHER'S MAIDEN NAME <i>Nora Mead</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Robert Learmonth</i> Address <i>Rockville, Md 9th</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>DIABETES Mellitus</i> DUE TO (c) <i>Hypertensive Arteriosclerotic Heart Disease</i> 10 years INTERVAL BETWEEN ONSET AND DEATH <i>12 HOURS</i> <i>2 YEARS</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Rheumatoid Arthritis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JAN</i> , 19 <i>50</i> , to <i>21 Sept</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>19 September</i> , 19 <i>58</i> , and that death occurred at <i>9:40 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Gordon Rosenberger</i> M.D.				DATE SIGNED <i>26 Nov 1958</i>			
PHYSICIAN'S NAME (Type) <i>GORDON ROSENBERGER</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>TRANS. & BURIAL</i>		<i>9/26/58</i>		<i>PERU CITY CEMETERY</i>		<i>PERU, ILLINOIS</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i> ADDRESS <i>SILVER SPRING, MD.</i>				24a. REC'D BY REGISTRAR DATE <i>SEP 23 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10374

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 31 hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Gertrude Lee				4. DATE OF DEATH Month Day Year September 23 19 58			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/6/08	
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME John Lee				14. MOTHER'S MAIDEN NAME Allie Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 626x Pelvic Abscess DUE TO (b) Pyosalpinx - Ruptured urinary Bladder DUE TO (c) Bronchopneumonia CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x Arteritis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept 21 , 19 58 , to Sept 23 , 19 58 , that I last saw the deceased alive on Sept 23 , 19 58 , and that death occurred at 9:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Olney, Maryland DATE SIGNED 9-24-58							
ACTUAL SIGNATURE Richard A. Yates				M.D. R. A. Yates, M. D.			
PHYSICIAN'S NAME (Type) R. A. Yates, M. D.				ADDRESS Olney, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/58		22c. NAME OF CEMETERY OR CREMATORY Oak Grove.,		22d. LOCATION (City, town, or county) (State) Mt. Zion, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE SEP 26 1958	
24b. REGISTRAR'S SIGNATURE Arthur S. Knaus							

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10286

CERTIFICATE OF DEATH

10351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montg</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Montg.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash Sanitarium</i>		d. STREET ADDRESS <i>12807-Harris St S Spg</i>	
3. NAME OF DECEASED (Type or print) First <i>MINNIE</i> Middle <i>LEOPOLD</i> Last <i>LEOPOLD</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>20</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-29-1888</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House duties</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Russia</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>SOLOMON BERGER</i>		14. MOTHER'S MAIDEN NAME <i>ESTHER BERGER</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>MELVIN ROMANCEFF</i>		Address <i>2807-HARRIS ST.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>204.4 LEUKEMIA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>3 YRS</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June</i> 19 <i>55</i> , to <i>Sept 20</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Sept 19</i> , 19 <i>58</i> , and that death occurred at <i>1A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Simon C. Weiner</i>		ADDRESS (Street, city or town, state) <i>100 Longfellow St NW</i> DATE SIGNED <i>Sept 20 1958</i>	
PHYSICIAN'S NAME (Type) <i>Simon C. Weiner</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-21-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Warsawer Relief Soc.</i>	22d. LOCATION (City, town, or county) (State) <i>NEW HAVEN CONN.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home Wash. DC</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>SEP 22 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10375
CERTIFICATE OF DEATH

10352

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2212 ROSS RD SILVER SPRING, MD.		d. STREET ADDRESS 2212 Ross Road	
3. NAME OF DECEASED (Type or print) Rose First Levine Middle Last		4. DATE OF DEATH Sept. 15 1958 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 25, 1902 9. AGE (In years lost birthday) 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zalman Murnik		14. MOTHER'S MAIDEN NAME Chaya - - -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sidney Levine Address 2203 Mark Court, Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERIO-SCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 6 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 to SEPT 15, 1958 , that I last saw the deceased alive on SEPT 15, 1958 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE LeRoy Robins M.D.		ADDRESS (Street, city or town) state 2480 - 16th NW DATE SIGNED 9-15-58	
PHYSICIAN'S NAME (Type) LeRoy Robins, M.D.		2480 16th St., N.W.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 17, 1958	22c. NAME OF CEMETERY OR CREMATORY ELESAVETGRAD CEM.	22d. LOCATION (City, town, or county) (State) WASHINGTON DC
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons ADDRESS 3501 14th St., NW.		24a. REC'D BY REGISTRAR SEP 18 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Thaw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10376

CERTIFICATE OF DEATH

Reg. Dist. No.

10353

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2½ days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) × Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 3510 Taylor Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jerome Middle J Last Lightfoot				4. DATE OF DEATH Month September Day 1 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 17, 1878	
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR: Months 79		IF UNDER 24 HRS. Hours 79 Min. 79			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wash. D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jerome Lightfoot				14. MOTHER'S MAIDEN NAME Lucy Whelshy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and tracheobronchitis 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Wrenia						INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 28, 1958 to September 1, 1958 , that I last saw the deceased alive on August 31, 1958 , and that death occurred at 1:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert H. Poole				ADDRESS (Street, city or town, state) 4630 Montgomery Ave., Bethesda, Md.			
PHYSICIAN'S NAME (Type) ROBERT N. COBLE				DATE SIGNED 9/1/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 9/3/58		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		22d. LOCATION (City, town, or county) (State) SUITLAND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Shook's Sons				ADDRESS 1750 Penna Ave NW		24a. REC'D BY REGISTRAR SEP 4 58	
				24b. REGISTRAR'S SIGNATURE Conrad S. Frawley			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12/5/29		6. BIRTH PLACE Jackson, Mississippi	
7. OCCUPATION Minister		8. MARITAL STATUS Single		9. EDUCATION High School	
10. CAUSE OF DEATH Myocardial Infarction		11. DATE OF DEATH 4/4/68		12. PLACE OF DEATH St. Louis, Missouri	
13. SIGNATURE OF PHYSICIAN [Signature]		14. SIGNATURE OF DEATH CERTIFICATE OFFICER [Signature]		15. SIGNATURE OF WITNESS [Signature]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF NEXT OF KIN [Signature]		18. SIGNATURE OF BURIAL OFFICER [Signature]	
19. SIGNATURE OF FUNERAL HOME [Signature]		20. SIGNATURE OF VITALS OFFICER [Signature]		21. SIGNATURE OF REGISTRAR [Signature]	
22. SIGNATURE OF CLERK [Signature]		23. SIGNATURE OF CHIEF OF BUREAU [Signature]		24. SIGNATURE OF DIRECTOR [Signature]	

THIS CERTIFICATE IS VALID FOR THE STATE OF MISSOURI ONLY. IT IS NOT VALID FOR ANY OTHER STATE OR COUNTRY.

10287

CERTIFICATE OF DEATH

10354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>6 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8502 Flower Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mamie Florene Lilly</i>		4. DATE OF DEATH Month Day Year <i>September 2 1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 14, 1866</i>
9. AGE (In years last birthday) <i>91</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Tenn.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>James A. Moore</i>	
14. MOTHER'S MAIDEN NAME <i>Mitchell</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>Morgan C. Smith, 8502 Flower Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0 Uremia</i> DUE TO (b) <i>Arterio sclerosis</i> DUE TO (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>14 days yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug 22, 1958</i> to <i>Sept 2, 1958</i> , that I last saw the deceased alive on <i>Sept 1, 1958</i> , and that death occurred at <i>1 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles W. Humphreys, M.D.</i>		ADDRESS (Street, city or town, state) <i>1746 K St. Wash, D.C.</i>	
PHYSICIAN'S NAME (Type) <i>Charles W. Humphreys, Jr.</i>		DATE SIGNED <i>9/2/58</i>	
22a. BURIAL CREMATION REMOVAL (Specify) <i>removal</i>	22b. DATE THEREOF <i>9/3/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Whiteville, Tenn.</i>	22d. LOCATION (City, town, or county) (State) <i>Whiteville, Tenn.</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Wash, D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 3 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10355
(10355)
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10377

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Maryland		c. LENGTH OF STAY IN 1b 13x-2		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc. 1502 Montgomery Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Joy		Middle Hazel		Last Lynes		4. DATE OF DEATH Month September		Day 21	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 19, 1958		9. AGE (In years last birthday) 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Born		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Frederick E. Lynes				14. MOTHER'S MAIDEN NAME Hazel Melson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hazel Hynes		Address 1502 Montgomery Road, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 17								INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/19, 1958 , to 9/21, 1958 , that I last saw the deceased alive on 9/21, 1958 , and that death occurred at 3:00 PM , from the causes and on the date stated above.									
ACTUAL SIGNATURE Charles S. Whitaker				ADDRESS (Street, city or town, state) CLARKSVILLE		DATE SIGNED 9-22-58			
PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.				M.D. MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-1958		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				ADDRESS Ellicott City, Md		24a. REC'D BY REGISTRAR SEP 26 58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2093361XV3

CERTIFICATE OF DEATH

DATE OF DEATH

NAME OF DECEASED

SEX

AGE

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

SEX

AGE

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

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PLACE OF BIRTH

DATE OF DEATH

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DATE OF DEATH

CAUSE OF DEATH

SEX

AGE

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

SEX

AGE

PLACE OF BIRTH

DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10356

10288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN <u>13 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>				d. STREET ADDRESS <u>5130 Willow Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-24-1870</u>	
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u>			
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William H. Martin</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Washington Sanitarium + Hosp. Records</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>450.0</u> DUE TO <u>Coronile Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Prostate</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>10 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>13 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9 Sept</u> , 19 <u>58</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7112 Willow Ave</u> DATE SIGNED <u>14 Sept</u> ACTUAL SIGNATURE <u>H. B. QUEEN</u> M.D. <u>TAKOMA PARK MD</u> 19 <u>58</u> PHYSICIAN'S NAME (Type) <u>H. B. QUEEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>2901 14th St., N.W.</u>				24a. REC'D BY REGISTRAR <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>	

10378

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 225 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Wesley Last MASON, Sr.				4. DATE OF DEATH Month September Day 15 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11 February 1903		9. AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR Months 16 Days X Hours 2	IF UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George MASON				14. MOTHER'S MAIDEN NAME Minnie BOWEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-II		17. INFORMANT (Son) Harry Wesley Mason, Jr. (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Squamous Cell 190.4 DUE TO of neck Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 18 mos DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 18 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 February , 19 58 , to 15 Sept. , 19 58 , that I last saw the deceased alive on 15 Sept. , 19 58 , and that death occurred at 5:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-17-58							
ACTUAL SIGNATURE M.C. Shea M.D.				PHYSICIAN'S NAME (Type) M.C. SHEA, LT, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. T. Taltavull ADDRESS Taltavull Funeral Home, 3619 14th St., Wash. D.C.				24a. REC'D BY REGISTRAR DATE SEP 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10379

CERTIFICATE OF DEATH

Reg. Dist. No.

10358
215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Diane Middle Katherine Last MC COMB				4. DATE OF DEATH Month September Day 4 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 May 1957		9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington State		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Gordon Stuart MC COMB				14. MOTHER'S MAIDEN NAME Donna Margaret GALLEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) (Same As #2) Gordon S. MC COMB			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 August , 19 58 , to 4 Sept. , 19 58 , that I last saw the deceased alive on 4 Sept. , 19 58 and that death occurred at 7:45P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-5-58							
ACTUAL SIGNATURE Robert C. Thomas M.D.				PHYSICIAN'S NAME (Type) Robert C. Thomas, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey ADDRESS 7357 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR SEP 9 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 4, Film G234, 10/9/58 for
10289
CERTIFICATE OF DEATH

10359

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Takoma Park Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ralls Nursning Home				d. STREET ADDRESS 5112 Wessling Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EVA Middle D Last McDEVITT				4. DATE OF DEATH Month Sept. Day 26 Year 19 58			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 6 Days 22		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Downes				14. MOTHER'S MAIDEN NAME Mary J Dyol			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT daughter		Address Helen Boyer-4708 Morgan Dr. Bh. Ch. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332x (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) GENERAL ARTERIOSCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH Sudden 10 YEARS 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE LEFT FEMUR - AUG. 1958						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT. 25, 1958 to SEPT. 26, 1958 that I last saw the deceased alive on SEPT. 25, 1958 , and that death occurred at 8 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Angle				ADDRESS (Street, city or town, state) 5009 Dec Roy Ave, Bethesda, Md. DATE SIGNED 9/26/58			
PHYSICIAN'S NAME (Type) ROBERT A. ANGLE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-58		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery.		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE SEP 30 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10380

CERTIFICATE OF DEATH

10360

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>33 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4209 McCain Court</u>			
3. NAME OF DECEASED (Type or print) First <u>Norma</u> Middle <u>K</u> Last <u>McLaughlin</u>				4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 4, 1872</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>			
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>ROSWELL KING</u>				14. MOTHER'S MAIDEN NAME <u>Mary Clayton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Grand daughter (Mrs. John Gorman)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arterial thrombosis</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> years DUE TO (c) <u>Hypertensive CVD</u> years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>gastrointestinal hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>9/1</u> , 19 <u>58</u> , to <u>9/16</u> , 19 <u>58</u> that I last saw the deceased alive on <u>9/16</u> , 19 <u>58</u> , and that death occurred at <u>2:35</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>ROCKVILLE, MD.</u> DATE SIGNED <u>9-17-58</u>							
ACTUAL SIGNATURE <u>S. Bowditch/Hunter Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>G. BOWDITCH HUNTER JR.</u> <u>ROCKVILLE, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 9-17-58</u>				22b. DATE THEREOF <u>9-17-58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Beech Wood Cemetery.</u>				22d. LOCATION (City, town, or county) (State) <u>New Rochelle, New York</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY,</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

10381

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 69 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 200 C Street, S. E. Apt. 101			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frank Middle Ball Last Melchior		4. DATE OF DEATH Month September Day 15 Year 1958					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1897	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 6 Days 15 Hours 15 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY House of Representatives		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William E. Melchior				14. MOTHER'S MAIDEN NAME Sarah E. Ball			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 280-22-3454		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asotemia 157 X DUE TO Metastatic carcinoma, Maxillary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of pancreas (c) ?						INTERVAL BETWEEN ONSET AND DEATH 2 wks 6 mos ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from July 8 , 19 58 , to September 15 , 19 58 , that I last saw the deceased alive on September 15 , 19 58 , and that death occurred at 6:15 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H.R. Silberman		M.D. The Clinical Center		ADDRESS (Street, city or town, state) National Institutes of Health		DATE SIGNED 9-15-58	
PHYSICIAN'S NAME (Type) Harold R. Silberman, M. D.				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 17 SEPT 1958	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEM.		22d. LOCATION (City, town, or county) ARLINGTON, VA.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE JAMES T. RYAN, INC.				ADDRESS 317 PA. AVE. S. E. DC 3		24a. RECEIVED BY REGISTRAR SEP 17 1958	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10362

10382

CERTIFICATE OF DEATH

Reg. Dist.-No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1717 Flora Lane				d. STREET ADDRESS 1717 FLORA LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle UNDERWOOD Last MILLER				4. DATE OF DEATH Month 9 Day 7 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/30/1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.		IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY u.s. Govt.		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILSON P. MILLER				14. MOTHER'S MAIDEN NAME MARY FENTON DARLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS MARY GARDNER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x cardio vascular renal disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO (c) 3 yrs				INTERVAL BETWEEN ONSET AND DEATH 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19 a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Aug 1958 to Sept 7 1958 , that I last saw the deceased alive on Sept 7 1958 , and that death occurred at 8:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. E. Quayle				ADDRESS (Street, city or town, state) 1800 Belmont St N.W. Washington D.C.			
DATE SIGNED 9-7-58							
PHYSICIAN'S NAME (Type) E. E. Quayle M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/10/58		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company				ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24. REC'D BY REGISTRAR SEP 9 '58	
25. REGISTRAR'S SIGNATURE Arthur S. Hines							

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

10383

CERTIFICATE OF DEATH

10363

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospt.				d. STREET ADDRESS 1713 W. Montg. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle (NMI) Last MILLS				4. DATE OF DEATH Month Sept. Day 3 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/ 62	
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR Months 5 Days 24		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME ? Mills				14. MOTHER'S MAIDEN NAME Carolynne Fletcher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Martha M. Looper-Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X 491X Cerebral Insufficiency DUE TO 15 YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 15 YEARS DUE TO 15 YEARS (c) Nephrosclerosis							INTERVAL BETWEEN ONSET AND DEATH 30 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 491X Bronchopneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from August 17, 1958 , to September 3, 1958 , that I last saw the deceased alive on September 1, 1958 , and that death occurred at 3 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon S. Rosenberger M.D.				ADDRESS (Street, city or town, state) 26 N. Summit Ave., Rockville, Md.			
DATE SIGNED Sept 3, 1958							
PHYSICIAN'S NAME (Type) Gordon S. Rosenberger-310				W. Montg. Ave., Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/58		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 5 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Krous			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 14 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10384

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 13 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. STREET ADDRESS 809 Crothers Lane			
3. NAME OF DECEASED (Type or print) First Margaret Middle Ellen Last MOORE				4. DATE OF DEATH Month September Day 8 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 March 1894		9. AGE (In years last birthday) yrs. 64	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James BEAL				14. MOTHER'S MAIDEN NAME Ellen BARBER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 011 03 7218		17. INFORMANT Address (Daughter) Mrs. Edna M. Smith (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Possible metastases from bronchogenic cancer DUE TO (c) 6 months						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 August , 19 58 , to 8 Sept. , 19 58 , that I last saw the deceased alive on 8 Sept. , 19 58 , and that death occurred at 4:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James M. Young M.D. U.S. Naval Hospital, Bethesda, Md. 9-9-58							
ACTUAL SIGNATURE James M. Young NAME (Type) James M. Young, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-10-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) 4000 Suitland Rd., Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS 551 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE SEP 10 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10088

Name of Deceased		Date of Death	
John Doe		10/15/1950	
Age		Sex	
45		Male	
Race		Marital Status	
White		Married	
Place of Birth		Date of Birth	
Baltimore, Md.		10/15/1905	
Cause of Death		Place of Death	
Heart Disease		Home	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Coronary Atherosclerosis	
Manner of Death		Signature of Physician	
Natural		[Signature]	
Certified by		Date	
[Signature]		10/16/1950	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10365

10385

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>53 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Kathryn</u> Last <u>MOORE</u>				4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>19 January 1914</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Colorado</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William SHAW</u>				14. MOTHER'S MAIDEN NAME <u>Louisa DAWE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>(Husband) Theophilus MOORE (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Liver Metastasis</u> DUE TO <u>Serous Cystadenocarcinoma, Lt. Ovary with</u> (c) <u>Generalized Metastases</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 Weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10 July</u> , 19 <u>58</u> , to <u>1 September</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1 Sept.</u> , 19 <u>58</u> , and that death occurred at <u>2:35 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas B. Lebhertz</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md. 9-2-58</u>			
PHYSICIAN'S NAME (Type) <u>Thomas B. Lebhertz, CDR, MC, USN</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-4-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gawler's & Sons, 1756 Penn. Ave., Wash, D.C.</u>				24a. RECEIVED BY REGISTRAR <u>SEP 3 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10366

10386

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONT. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo	
d. NAME OF HOSPITAL (If not in hospital, give street address) 200 Wellesley Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NANNIE E MOORE		4. DATE OF DEATH Month Sept. Day 16 Year 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH aug. 12, 1870
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Liddy		14. MOTHER'S MAIDEN NAME Mary Elmira Walrath	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mrs. Ruth E.M. Long		Address 200 Wellesley Ave. Glen Echo, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 13 yrs INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 55 , to Sept , 19 58 , that I last saw the deceased alive on Sept 14 , 19 58 , and that death occurred at 1145 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo I Donovan M.D.		ADDRESS (Street, city or town, state) 8016 Georgetown Road Bethesda, Md	
PHYSICIAN'S NAME (Type) LEO I DONOVAN MD		DATE SIGNED 9/17/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlikowski		ADDRESS 1756 Pa. Ave. NW, DC	
24a. REC'D BY REGISTRAR SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. [illegible]	

CERTIFICATE OF DEATH

1928

NAME OF DECEASED James E. Liddy		SEX Male	
DATE OF BIRTH Nov. 12, 1890		AGE 37	
PLACE OF BIRTH Chicago, Ill.		RACE White	
OCCUPATION Not stated		CAUSE OF DEATH Myocardial infarction	
PLACE OF DEATH Home		TIME OF DEATH 11:00 A.M.	
DATE OF DEATH Nov. 12, 1928		TIME OF DEATH 11:00 A.M.	
NAME OF PHYSICIAN Dr. J. E. Liddy		NAME OF FUNERAL HOME Not stated	
NAME OF BURIAL PLACE Cedar Hill Cemetery		NAME OF MINISTER Not stated	
NAME OF NEXT OF KIN Not stated		NAME OF WITNESS Not stated	
NAME OF REGISTRAR Not stated		NAME OF CLERK Not stated	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10367

Reg. Dist. No.

10387

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Barnesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clia</u> Middle <u>Thomas</u> Last <u>Morningstar</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July-22-1879</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Morningstar</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Buckey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Russell Kinna, Cornus, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>severance of art. Auricular artery (rt)</u> DUE TO (c) <u>laceration of scalp</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead on stair step</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of 2nd, 3rd & 4th ribs (left)</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stair step at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>22</u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Barnesville Monty md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosehart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 24-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) <u>Beallville md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton, Barnesville Md</u>		24a. REC'D BY REGISTRAR <u>SEP 25 '58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State and if Health, or its designated agent, prior to burial, cremation, or removal, and file page 3 with the State and if Health, or its designated agent, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE FOLLOWING INFORMATION
WAS OBTAINED FROM THE
DECEASED'S NEAREST
RELATIVE OR PERSON
HAVING KNOWLEDGE OF
THE DECEASED'S
IDENTITY AND RESIDENCE
AT THE TIME OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY	
SIGNATURE OF NEAREST RELATIVE		DATE		TIME		PLACE		CITY	
SIGNATURE OF PERSON HAVING KNOWLEDGE		DATE		TIME		PLACE		CITY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G233 9-15-68 mt

10388

CERTIFICATE OF DEATH

Reg. Dist. No.

10368

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 23 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1334 South 28th Street	
3. NAME OF DECEASED (Type or print) First William Middle Robert Clayton Last Morrison		4. DATE OF DEATH Month September Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1904
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advisor		10b. KIND OF BUSINESS OR INDUSTRY Government	11. BIRTHPLACE (State or foreign country) Manitoba
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Norman Morrison	
14. MOTHER'S MAIDEN NAME Rachel (unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Press	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage, Perforation of Intestines and Peritonitis 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Atherosclerotic Hypertensive Cardiovascular Disease: a. Recent Myocardial Infarction. b. Chronic Congestive Heart Failure. c. Peripheral Arterial Insufficiency.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 13, 1958 , to September 5, 1958 , that I last saw the deceased alive on September 5, 1958 , and that death occurred at 2:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. O. Barnett		DATE SIGNED 9/6/58	
PHYSICIAN'S NAME (Type) G. O. BARNETT, M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-9-58	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W. B. Mountcastle		24a. REC'D BY REGISTRAR SEP 8 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Hanks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1932

Age of Deceased

Northampton

Residence

Married

Occupation

1932

1932

1932

The Official Cause of Death is: *Heart Disease*

Age

Heart Disease

Location

Signature

Date

Time

Heart Disease

Signature

Signature

Signature

Heart Disease

Heart Disease

Heart Disease

Heart Disease

Heart Disease

Heart Disease

Heart Disease

Heart Disease

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Heart Disease

Heart Disease

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10369

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10389

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>321 Brown St.</u>			d. STREET ADDRESS <u>321 Brown St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Vernon William Moses</u>			4. DATE OF DEATH Month Day Year <u>Sept. 12, 1958</u> <u>19</u>		
5. SEX <u>36</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/21</u>		9. AGE (In years last birthday) <u>36</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>auto.</u>		11. BIRTHPLACE (State or foreign country) <u>Mt Nebo. W. Va</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Moses</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Keefer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>235 28 5110</u>		17. INFORMANT <u>Mary Doss Moses. Washington Grove. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & Laceration</u> <u>981X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Compound fracture of skull</u> DUE TO (c) <u>Shot gun wound</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted shot gun wound of skull (head decapated)</u>			
20c. TIME OF INJURY Month, Day, Year Hour Min. P. M. <u>9/12/58</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Washington Grove Montg. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>9-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gilgal Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Mt Nebo. W. Va.,</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u>			24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Hanna</u>

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Clagettsville				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD Monrovia				/d. STREET ADDRESS RFD Monrovia			
3. NAME OF DECEASED (Type or print) First Middle Last Ollie W. Moxley				4. DATE OF DEATH Month Day Year Sept. 18 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1880		9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Clagettsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Moxley				14. MOTHER'S MAIDEN NAME Sarah Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Raymond M. Moxley, Monrovia, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 19 1952 , to Sept. 18 1958 , that I last saw the deceased alive on Sept. 9 1958 , and that death occurred at 2 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md.			
PHYSICIAN'S NAME (Type) James P. Kerr				DATE SIGNED 9/17/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 20, 1958		22c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		22d. LOCATION (City, town, or county) (State) Clagettsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. L. Moleworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR SEP 22 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>MALE</u>		3. AGE <u>65</u>	
4. DATE OF DEATH <u>10/15/1968</u>		5. TIME OF DEATH <u>10:30 AM</u>		6. PLACE OF DEATH <u>HOME</u>	
7. CAUSE OF DEATH <u>HEART DISEASE</u>		8. MANNER OF DEATH <u>NATURAL</u>		9. PLACE OF BIRTH <u>NEW YORK</u>	
10. OCCUPATION <u>RETIRED</u>		11. MARITAL STATUS <u>MARRIED</u>		12. EDUCATION <u>HIGH SCHOOL</u>	
13. PREVIOUS ILLNESS <u>HYPERTENSION</u>		14. PRESENT ILLNESS <u>HEART DISEASE</u>		15. MEDICAL HISTORY <u>NO</u>	
16. SIGNATURE OF PHYSICIAN <u>DR. J. SMITH</u>		17. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		18. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
19. SIGNATURE OF DECEASED <u>JOHN J. SMITH</u>		20. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		21. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
22. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		23. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		24. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
25. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		26. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		27. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
28. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		29. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		30. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
31. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		32. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		33. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
34. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		35. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		36. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
37. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		38. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		39. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
40. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		41. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		42. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
43. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		44. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		45. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
46. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		47. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		48. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
49. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		50. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		51. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
52. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		53. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		54. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
55. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		56. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		57. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
58. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		59. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		60. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
61. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		62. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		63. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
64. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		65. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		66. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
67. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		68. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		69. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
70. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		71. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		72. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
73. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		74. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		75. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
76. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		77. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		78. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
79. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		80. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		81. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
82. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		83. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		84. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
85. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		86. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		87. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
88. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		89. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		90. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
91. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		92. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		93. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
94. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		95. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		96. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
97. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		98. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		99. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	
100. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		101. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>		102. SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	

THIS CERTIFICATE OF DEATH IS TO BE COMPLETED BY THE PHYSICIAN WHO HAS TENDERS THE BODY OF THE DECEASED. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. THE REGISTRAR OF DEATHS SHALL BE RESPONSIBLE FOR THE COMPLETION OF THIS CERTIFICATE OF DEATH. THE REGISTRAR OF DEATHS SHALL BE RESPONSIBLE FOR THE COMPLETION OF THIS CERTIFICATE OF DEATH. THE REGISTRAR OF DEATHS SHALL BE RESPONSIBLE FOR THE COMPLETION OF THIS CERTIFICATE OF DEATH.

10391

CERTIFICATE OF DEATH

10371

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring c. LENGTH OF STAY IN 1b 5 mo. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring d. STREET ADDRESS Box 141 Brooke Grove Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Norma Middle Jean Last Mullen		4. DATE OF DEATH Month September Day 18 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/7/58
9. AGE (In years lost birthday) yrs. 5		IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min. 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Norman Eugene Mullen		14. MOTHER'S MAIDEN NAME Merle Elaine Hopkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Montgomery Co. General Hosp. Records, Olney, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Aspiration of vomitus DUE TO Lobar Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Bronchopneumonia (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Measenteric Lymphadenitis		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 7 , 19 58 to Sept 18 , 19 58 , that I last saw the deceased alive on Sept 17 , 19 58 , and that death occurred at 3:00 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9/18/58			
ACTUAL SIGNATURE C. H. Ligon, M. D.		M. D.	
PHYSICIAN'S NAME (Type) C. H. Ligon, M. D.		Sandy Spring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 9/20/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Sandy Spring		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md	
24a. REC'D BY REGISTRAR SEP 24 58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073192XVI

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

10392

CERTIFICATE OF DEATH

10372

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 8 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus	
3. NAME OF DECEASED (Type or print) First Middle Last Dora S. Mullinix		4. DATE OF DEATH Month Day Year Sept. 7 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Clarksburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. King		14. MOTHER'S MAIDEN NAME Addie C. Hurley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Bone	
17. INFORMANT Claude G. Mullinix, Mt. Airy, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral & General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular-Renal Disease c DUE TO Hypertension. (c)		INTERVAL BETWEEN ONSET AND DEATH July 9, 1958 10 yrs. 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January , 19 38 , to September 7, 1958 . I last saw the deceased alive on Sept. 6, 19 58 , and that death occurred at 5:16: A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Damascus, Maryland.	
ACTUAL SIGNATURE M. McKendree Boyer, M.D.		DATE SIGNED 9/7/58	
PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.		ADDRESS Druid Theatre Building, Damascus, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 9, 1958	22c. NAME OF CEMETERY OR CREMATORY Howard Chapel	22d. LOCATION (City, town, or county) (State) Long Corner, Howard Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Chas. L. Wolsworth		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR SEP 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10393

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 7 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dover		46 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS RD #4	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Ann MUSPRATT		4. DATE OF DEATH Month Day Year September 30 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1958
9. AGE (In years last birthday) yrs. 6		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Paul Alexander MUSPRATT		14. MOTHER'S MAIDEN NAME Loretta Rebecca PULLEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father, Paul A. Muspratt, same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tetralogy of Fallot 7540 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 19		(County) (State)	
21. I certify that I attended the deceased from 9-24- 1958 , to 9-30 1958 , that I last saw the deceased alive on 9-30 1958 , and that death occurred at 2:40P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. E. Mc Clenathan</i>		ADDRESS (Street, city or town, state) W. S. Naval Hospital, NNMC	
PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN Bethesda 14, Maryland		DATE SIGNED 10-1-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-5-58	
22c. NAME OF CEMETERY OR CREMATORY Silver Brook Cemetery		22d. LOCATION (City, town, or county) (State) Wilmington Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Adams Funeral Home</i>		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR 3 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

— 5 —

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10374

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> c. LENGTH OF STAY IN 1b <u>12 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4105 Sycamore St</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> d. STREET ADDRESS <u>4105 Sycamore St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LILIAN Haigh Nicholl</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-9-1902</u> 9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>27</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>		4. DATE OF DEATH <u>Sept 30</u> 19 <u>58</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (State or foreign country) <u>md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wm Haigh</u> 14. MOTHER'S MAIDEN NAME <u>Joan Lillian Cox</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Joan Nicholl</u> Address <u>3508 O St, Wash. Dc</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>977x Hemorrhage</u> DUE TO (b) <u>lacerations of left wrist</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple sclerosis 3 or 4 yrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Self-inflicted laceration of left wrist</u> 20c. TIME OF INJURY Month, Day, Year <u>9-30 1958</u> Hour <u>7</u> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>home</u> (City or town) <u>Cherry Chase Monty</u> (County) <u>md</u> (State) <u>md</u>		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checkbox"="" checked="" type="checkbox/> and in my opinion death resulted from: Natural causes <input type="/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 	
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-30-58</u> DATE SIGNED		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>10-3-58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> 22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u> (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u> 24a. REC'D BY REGISTRAR <u>258</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10375

10395 **CERTIFICATE OF DEATH**

Items 2, 11, 13, 14 Film G234 10-15-58 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montg</u>		MARYLAND		STATE <u>?</u>		COUNTY <u>?</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring Rural</u>		LENGTH OF STAY (in this place) <u>2 Yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>?</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Marilea Rest Home, 14511 Colaville Rd</u>				STREET ADDRESS <u>?</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Catherine North</u>				4. DATE OF DEATH (Month) <u>Sept</u> (Day) <u>27</u> (Year) <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Eig. Bldg r Howard Thomas. Silverspring</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Involuntarily asphyxiated</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-3</u>, 19<u>58</u>, to <u>9-27</u>, 19<u>58</u>, that I last saw the deceased alive on <u>9-25</u>, 19<u>58</u>, and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>1919 Langford Rd Silver Spring Md</u>		DATE SIGNED <u>9-27-58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-1-58</u>		NAME OF CEMETERY OR CREMATORY <u>Montg. Co.</u>		LOCATION (City, town, or county) (State) <u>Rockville Md.</u>	
24. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner.</u>		ADDRESS <u>Calithersburg. Md.</u>	
DATE <u>OCT 2 '58</u>							

CERTIFICATE OF DEATH

10030

Rev. 10-1-19

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. DATE OF DEATH

13. PLACE OF DEATH

14. TIME OF DEATH

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. DATE OF DEATH

18. PLACE OF DEATH

19. TIME OF DEATH

20. SIGNATURE OF PHYSICIAN

21. SIGNATURE OF REGISTRAR

22. DATE OF DEATH

23. PLACE OF DEATH

24. TIME OF DEATH

25. SIGNATURE OF PHYSICIAN

26. SIGNATURE OF REGISTRAR

27. DATE OF DEATH

28. PLACE OF DEATH

29. TIME OF DEATH

REGISTRATION

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH THE REGISTRAR WITH A COPY OF IT. IT IS THE DUTY OF THE REGISTRAR TO FURNISH A COPY OF THIS CERTIFICATE OF DEATH TO THE FAMILY OF THE DECEASED AND TO FURNISH A COPY OF IT TO THE STATE DEPARTMENT OF HEALTH. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH THE REGISTRAR WITH A COPY OF IT. IT IS THE DUTY OF THE REGISTRAR TO FURNISH A COPY OF THIS CERTIFICATE OF DEATH TO THE FAMILY OF THE DECEASED AND TO FURNISH A COPY OF IT TO THE STATE DEPARTMENT OF HEALTH.

10396

CERTIFICATE OF DEATH

Reg. Dist. No.

10376

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS Barnesville			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Steven Last Offutt				4. DATE OF DEATH Month September Day 24 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/45		9. AGE (In years last birthday) 13 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jerome Offutt				14. MOTHER'S MAIDEN NAME Mary Loretta Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Hospital Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Bacterial DUE TO Broncho Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pseudo Hypertrophic DUE TO Muscular Dystrophy (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							INTERVAL BETWEEN ONSET AND DEATH 4 days 11 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 21, 1958 , to Sept. 24, 1958 , that I last saw the deceased alive on Sept. 24, 1958 , and that death occurred at 9:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED Sept. 25, 1958							
ACTUAL SIGNATURE Jack Schumacher M.D.				PHYSICIAN'S NAME (Type) Dr. Jack Schumacher Eaithersburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 27-58		22c. NAME OF CEMETERY OR CREMATORY St Mary's		22d. LOCATION (City, town, or county) (State) Barnesville Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton				ADDRESS Barnesville, Md.		24a. REC'D BY REGISTRAR SEP 29 58	
				24b. REGISTRAR'S SIGNATURE W. B. Hilton			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10308

TAMM BOND

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Post-mortem Examination	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness	
Date of Report		Time of Report		Place of Report		Signature of Reporter	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10397

CERTIFICATE OF DEATH

Reg. Dist. No.

10377

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 2915 Connecticut Avenue, N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James William O'Hara, Sr.		4. DATE OF DEATH Month Day Year September 4, 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 July 1887
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Agent		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James J. O'Hara		14. MOTHER'S MAIDEN NAME Ellen Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 706-14-8228	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory arrest - cerebral ischemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) uremia DUE TO (c) hypertension		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9, 1958 , to September 4, 1958 , that I last saw the deceased alive and September 4, 19 58 , and that death occurred at 9:55 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene B. Feigelson		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/5/58	
PHYSICIAN'S NAME (Type) Eugene B. Feigelson, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-8-58	22c. NAME OF CEMETERY OR CREMATORY SS PETER & PAUL CEM.	22d. LOCATION (City, town, or county) (State) ELMIRA, N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE Francis Collins ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR SEP 8 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10398

CERTIFICATE OF DEATH

Reg. Dist. No. 10378

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution/Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10617-EDGEWOOD AVE.</u>				d. STREET ADDRESS <u>10617-EDGEWOOD AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>P. V.</u> Middle <u>O'HARA</u> Last		4. DATE OF DEATH <u>9</u> Month <u>29</u> Day <u>19</u> Year <u>58</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 25, 1881</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WHOLESALE BUS.</u>		11. BIRTHPLACE (State or foreign country) <u>WINCHESTER MASS.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>FRANCIS J. O'HARA</u>				14. MOTHER'S MAIDEN NAME <u>JANE DONAHUE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>010-10-8556</u>		17. INFORMANT <u>THOMAS FORD</u> Address <u>10617-EDGEWOOD AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY ASPIRATION-VOMITUS</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC SENILITY</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>X</u> <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/7</u> , 19 <u>58</u> , to <u>9/29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/25</u> , 19 <u>58</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10011 Georgia Ave Silver Spring Maryland</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Henry W. Stout</u> M.D. PHYSICIAN'S NAME (Type) <u>HENRY W. STOUT</u>							
22a. BURIAL-CREMATATION <u>None</u>		22b. DATE THEREOF <u>10-2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulen</u> ADDRESS <u>3831-GA. AVE.</u>				24a. REC'D BY REGISTRAR <u>3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Haulen</u>	

CERTIFICATE OF DEATH

10038

<p>1. NAME OF DECEASED <i>James J. Jones</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>65</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1893</i></p>		<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>	
<p>6. OCCUPATION <i>Retired</i></p>		<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF DEATH <i>Dec 10 1958</i></p>		<p>9. PLACE OF DEATH <i>Home</i></p>		<p>10. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>11. MEDICAL HISTORY <i>None</i></p>		<p>12. PRESENT ILLNESS <i>None</i></p>		<p>13. DATE OF ONSET <i>None</i></p>		<p>14. PLACE OF ONSET <i>None</i></p>		<p>15. DATE OF TERMINATION <i>None</i></p>	
<p>16. SIGNATURE OF PHYSICIAN <i>J. J. Jones</i></p>		<p>17. SIGNATURE OF DECEASED <i>J. J. Jones</i></p>		<p>18. SIGNATURE OF WITNESS <i>J. J. Jones</i></p>		<p>19. SIGNATURE OF DECEASED <i>J. J. Jones</i></p>		<p>20. SIGNATURE OF WITNESS <i>J. J. Jones</i></p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

10399

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8904 FLOWER AVENUE				d. STREET ADDRESS 8904 FLOWER AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANDREW Middle F. Last OTT				4. DATE OF DEATH Month 9 Day 26 Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-86		9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machanist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN OTT				14. MOTHER'S MAIDEN NAME LOUISE SCHULER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-32-9167		17. INFORMANT Address SILVER SPRING, MD. MRS. S.M. DEFFINBAUGH 8904 Flower Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis DUE TO (c) Generalized Atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/30 , 19 54 to 9/26 , 19 58 , that I last saw the deceased alive on 9/26 , 19 58 , and that death occurred at 1218 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A.C. LEONARDO		ADDRESS (Street, city or town, State) 5801-13th St NW DATE SIGNED					
PHYSICIAN'S NAME (Type) A.C. LEONARDO							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-58		22c. NAME OF CEMETERY OR CREMATORY Ft. Linclon Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS WASH. D. C. 14th, St. N. W.		24a. REC'D BY REGISTRAR SEP 30 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10380

10290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>Do A.</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sanitarium + Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>N M N</u> Last <u>Pappas</u>				4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1958</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-3-98</u>			
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>16</u> Min. <u>X-2</u>		IF UNDER 24 HRS. Months <u>9</u> Days <u>9</u> Hours <u>16</u> Min. <u>X-2</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>					
11. BIRTHPLACE (State or foreign country) <u>Greece</u>				12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>					
13. FATHER'S NAME <u>Peter Pappas</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>195-09-4339</u>					
17. INFORMANT <u>John Pappas</u> Address <u>8113 Riggs Rd. Adelphi, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden cardiac failure</u> 434.4 DUE TO <u>Cardiac hypertrophy + mitral regurgitation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Essential hypertension</u> (c) <u>2 years</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>9/5</u> , 19 <u>58</u> , to <u>9/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/8</u> , 19 <u>58</u> , and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Eino Magi</u>				ADDRESS (Street, city or town, state) <u>918 University Blvd. East, Silver Spring, Maryland</u>					
DATE SIGNED <u>9/10/58</u>									
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>9/12/58</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zicka</u>				ADDRESS <u>SILVER SPRING, MD.</u>					
24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>					

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

10400

CERTIFICATE OF DEATH

Reg. Dist. No.

10381

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY Union			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Plainfield 67x-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 203 View Avenue			
3. NAME OF DECEASED (Type or print) First Francine Middle (none) Last Pascale				4. DATE OF DEATH Month September Day 4 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 27, 1932	
				9. AGE (In years last birthday) yrs. 25		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker				10b. KIND OF BUSINESS OR INDUSTRY Office Work		11. BIRTHPLACE (State or foreign country) New Jersey	
13. FATHER'S NAME Frank Pascale				14. MOTHER'S MAIDEN NAME Loretta Pearly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 754.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) postoperative Left subclavian-pulmonary artery anastomosis + aortic valvulotomy (c) Congenital Heart Disease, Tetralogy of Fallot							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 17, 19 58 , to September 4, 19 58 , that I last saw the deceased alive on September 4, 19 58 , and that death occurred at 3:10 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE N. Perryman Collins				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) N. Perryman Collins, M. D.				DATE SIGNED 9/5/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 9/9/58				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 9 '58	
						24b. REGISTRAR'S SIGNATURE Christina S. Hanna	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11540

10401

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville 26</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>608 Monroe St.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl Patterson</u>		4. DATE OF DEATH <u>September 20 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 20 1958</u>
9. AGE (In years last birthday) <u>6</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emitt Donald Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Vera Elizabeth Heath</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>mother</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-20-58</u> , 19 <u>58</u> , to <u>9-20-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-20-58</u> , 19 <u>58</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
22. PHYSICIAN'S NAME (Type) <u>Dr. John R. Bonley</u> M.D. <u>2716 Howard Ave Kensington Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9-23-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hosp.</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <u>OCT 10 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2074181x40

1 5 50 1 2 1 VS A15 (4) ISM 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3, 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10402

CERTIFICATE OF DEATH

Reg. Dist. No. 10382

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1318 Chestnut Street			
3. NAME OF DECEASED (Type or print) First Franklin Middle Ray Last Payne				4. DATE OF DEATH Month September Day 16 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1, 1921	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Inmon H. Payne		14. MOTHER'S MAIDEN NAME Goldie Stickles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 231-12-9548		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) Rheumatic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 3-4 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Possible Laennec's Cirrhosis				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 3, 1958 , to September 16, 1958 , that I last saw the deceased alive on September 16, 1958 , and that death occurred at 2:10 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Jean Donald Wilson				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/16/58			
PHYSICIAN'S NAME (Type) Jean Donald Wilson, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-58		22c. NAME OF CEMETERY OR CREMATORY Hillsboro		22d. LOCATION (City, town, or county) (State) Hillsboro, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Money + King Funeral Home ADDRESS 171 Maple Ave. W. Vienna, Va.				24a. REC'D BY REGISTRAR SEP 19 58 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

Reg. Dist. No.

10403

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b Carroll Hall Sanitarium d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY Washington 47X-3 5226 MacArthur Blvd. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BEULAH Middle Last PENDILL		4. DATE OF DEATH Month SEPT Day 26 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 73
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Raymond Rogers		14. MOTHER'S MAIDEN NAME Ruby Shedd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Vivian M. Struble-5226 MacArthur Blvd.		Address Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE HEART DISEASE DUE TO (c) ESSENTIAL HYPERTENSION			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PERICARDITIS WITH EFFUSION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from APRIL 3 1958 to SEPT. 26, 1958 , that I last saw the deceased alive on SEPT. 26, 1958 , and that death occurred at 14 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry L. Louden M.D.		ADDRESS (Street, city or town, state) 5206 NORWAY DR NW DATE SIGNED 9/1/58	
PHYSICIAN'S NAME (Type) CHEVY CHASE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 9/27/58	22c. NAME OF CEMETERY OR CREMATORY Burlington Cemetery	22d. LOCATION (City, town, or county) (State) Burlington, Michigan
23. FUNERAL DIRECTOR'S SIGNATURE The S.A. Pine Co.		24a. REC'D BY REGISTRAR 29 SEP 58	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10404

CERTIFICATE OF DEATH

10384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
c. LENGTH OF STAY IN 1b 38 Days		d. STREET ADDRESS 14 Quincy Place, N. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sudie Middle Mae Last Phillips		4. DATE OF DEATH Month September Day 4 Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1922
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Upholstering	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Phillips		14. MOTHER'S MAIDEN NAME Lena Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 242-34-0196	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AORTIC INSUFFICIENCY DUE TO (c) MARFAN'S SYNDROME		INTERVAL BETWEEN ONSET AND DEATH 36 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 28, 1958 , to September 4, 1958 , that I last saw the deceased alive on September 4, 1958 , and that death occurred at 5:05 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Oates, Jr., M.D. M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) John A. Oates, Jr., M.D.		DATE SIGNED 9/5/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-7-58	
22c. NAME OF CEMETERY OR CREMATORY Church		22d. LOCATION (City, town, or county) (State) Rockville, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. R. Bacon		ADDRESS 1722 7th St NW	
24a. REC'D BY REGISTRAR SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kinsell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10440

<p>1. Name of deceased: <i>John A. Smith</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 15, 1915</i></p>		<p>4. Place of birth: <i>St. Louis, Mo.</i></p>	
<p>5. Date of death: <i>Jan 20, 1965</i></p>		<p>6. Place of death: <i>St. Louis, Mo.</i></p>	
<p>7. Cause of death: <i>Myocardial infarction</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>John A. Smith</i></p>		<p>10. Signature of registrar: <i>John A. Smith</i></p>	
<p>11. Signature of medical examiner: <i>John A. Smith</i></p>		<p>12. Signature of coroner: <i>John A. Smith</i></p>	
<p>13. Signature of funeral director: <i>John A. Smith</i></p>		<p>14. Signature of undertaker: <i>John A. Smith</i></p>	
<p>15. Signature of cemetery: <i>John A. Smith</i></p>		<p>16. Signature of interment: <i>John A. Smith</i></p>	
<p>17. Signature of burial: <i>John A. Smith</i></p>		<p>18. Signature of cremation: <i>John A. Smith</i></p>	
<p>19. Signature of other: <i>John A. Smith</i></p>		<p>20. Signature of other: <i>John A. Smith</i></p>	

10405

CERTIFICATE OF DEATH

10385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write <u>5123 Worthington Dr.</u>) c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write <u>Chevy Chase</u>)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chevy Chase, Md.</u>		d. STREET ADDRESS <u>5123 Worthington Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Edna Pindell</u>		4. DATE OF DEATH <u>Sept 12</u> 19 <u>58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/88</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Stephens</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Beecher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>William Hamilton Pindell same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Has been in chronic failure since Dec. 1956</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>years</u> <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 26, 1947</u> , to <u>today</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-12-</u> 19 <u>58</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>C. P. Ryland</u> M.D. <u>9-12-58</u> <u>4100 - 49th St., N. W.</u> <u>Washington 16, D. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>9/12/58</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10386

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery 10406 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's d. STREET ADDRESS Bucklarge Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Phyllis Victoria Plummer		4. DATE OF DEATH Month Day Year September 4 1958		5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 7-57		9. AGE (In years last birthday) yrs. 10 Months 27 Days 27 Hours 27 Min.			
10a. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) md				12. CITIZEN OF WHAT COUNTRY? MSA			
13. FATHER'S NAME Carroll William Plummer						14. MOTHER'S MAIDEN NAME Della Virginia Simms									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Della V. Plummer - Boyd's, md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Hemorrhage, Bilateral 492X DUE TO (b) Aspiration Gastric Contents Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Interstitial Pneumonia												INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Boyd's		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Frank J. Brochart						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED			
EXAMINER'S NAME (Type) FRANK J. Brochart						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		9-4-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-6-58		22c. NAME OF CEMETERY OR CREMATORY St. Marks				22d. LOCATION (City, town, or county) Boyd, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden						ADDRESS Rockville, Md.						24a. REC'D BY REGISTRAR SEP 8 1958		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10407

CERTIFICATE OF DEATH

10387

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd R.F.D c. LENGTH OF STAY IN 1b 2 dys d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson---R.F.D # 1 d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle Elizabeth Last Poston		4. DATE OF DEATH Month Sept 13 Day 30X Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27-1872
9. AGE (In years birth day) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME John Poston		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mrs Phillis Ningrad, 3109-Parkway, Baltimore, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 48 hours 2 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1957 to 13 Sept. 1958 , that I last saw the deceased alive on 12 Sept 1958 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		ADDRESS (Street, city or town, state) BARNESVILLE, MD DATE SIGNED 14 Sept 58	
PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 23-58	22c. NAME OF CEMETERY OR CREMATORY Greenville	22d. LOCATION (City, town, or county) (State) Berryville, Va
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Helton ADDRESS Barnesville, Md.		24a. REC'D BY REGISTRAR SEP 16 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Huns

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10408

CERTIFICATE OF DEATH

Reg. Dist. No. 10388

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Tazewell			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 119 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eddie Middle Dean Last Powers				4. DATE OF DEATH Month September Day 1 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 2, 1955	
9. AGE (In years last birthday) 2 yrs		10. IF UNDER 1 YEAR Months 11 Days 29		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charlie Powers				14. MOTHER'S MAIDEN NAME Lodina Beavers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 purulent meningitis DUE TO (b) acute lymphocytic leukemia DUE TO (c) 17 mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 bronchopneumonia; gastrointestinal hemorrhage							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 5 , 19 58 , to September 1 , 19 58 , that I last saw the deceased alive on September 1 , 19 58 , and that death occurred at 12:05 A. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold R. Silberman M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9-1-58			
PHYSICIAN'S NAME (Type) Harold R. Silberman, M. D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 9/2/58		22c. NAME OF CEMETERY OR CREMATORY Powers Cemetery		22d. LOCATION (City, town, or county) (State) Amonate, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE SEP 4 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1950

NAME OF DECEASED WILLIAM BROMID		DATE OF BIRTH 1912	PLACE OF BIRTH NEW YORK
SEX MALE		DATE OF DEATH 1950	PLACE OF DEATH BALTIMORE
OCCUPATION DRUGGIST		CAUSE OF DEATH HEART DISEASE	
DISEASE OR INJURY HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN DR. J. H. BROWN		SIGNATURE OF REGISTRAR JOHN D. SMITH	
DATE OF SIGNATURE 1950		DATE OF SIGNATURE 1950	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10389

10409

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 45 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencer		85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 113 Cross Street, Box 224		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Carol		Middle Jean		Last Propps	
4. DATE OF DEATH		Month September		Day 21,		Year 1958	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1945	
9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Ernest L. Propps		14. MOTHER'S MAIDEN NAME Irma Engel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute lymphocytic leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 15 Mths	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 7, 1958 , to September 21, 1958 , that I last saw the deceased alive on September 21, 1958 , and that death occurred at 1:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James M. Marsh				DATE SIGNED 9/21/58			
PHYSICIAN'S NAME (Type) James M. Marsh, M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/24/58		22c. NAME OF CEMETERY OR CREMATORY —		22d. LOCATION (City, town, or county) (State) Spencer, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 1400 Chapin St NW Washington		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	
24a. REC'D BY REGISTRAR SEP 24 '58				DATE			

CERTIFICATE OF DEATH

1918

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68		4. DATE OF BIRTH Jan 15 1850	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Retired		7. CAUSE OF DEATH Heart Failure		8. PLACE OF DEATH Home	
9. NAME OF PHYSICIAN Dr. J. H. Harris		10. NAME OF FUNERAL HOME None		11. NAME OF BURIAL PLACE None		12. NAME OF CEMETERY None	
13. NAME OF WITNESS J. H. Harris		14. NAME OF WITNESS J. H. Harris		15. NAME OF WITNESS J. H. Harris		16. NAME OF WITNESS J. H. Harris	
17. NAME OF WITNESS J. H. Harris		18. NAME OF WITNESS J. H. Harris		19. NAME OF WITNESS J. H. Harris		20. NAME OF WITNESS J. H. Harris	
21. NAME OF WITNESS J. H. Harris		22. NAME OF WITNESS J. H. Harris		23. NAME OF WITNESS J. H. Harris		24. NAME OF WITNESS J. H. Harris	
25. NAME OF WITNESS J. H. Harris		26. NAME OF WITNESS J. H. Harris		27. NAME OF WITNESS J. H. Harris		28. NAME OF WITNESS J. H. Harris	
29. NAME OF WITNESS J. H. Harris		30. NAME OF WITNESS J. H. Harris		31. NAME OF WITNESS J. H. Harris		32. NAME OF WITNESS J. H. Harris	
33. NAME OF WITNESS J. H. Harris		34. NAME OF WITNESS J. H. Harris		35. NAME OF WITNESS J. H. Harris		36. NAME OF WITNESS J. H. Harris	
37. NAME OF WITNESS J. H. Harris		38. NAME OF WITNESS J. H. Harris		39. NAME OF WITNESS J. H. Harris		40. NAME OF WITNESS J. H. Harris	
41. NAME OF WITNESS J. H. Harris		42. NAME OF WITNESS J. H. Harris		43. NAME OF WITNESS J. H. Harris		44. NAME OF WITNESS J. H. Harris	
45. NAME OF WITNESS J. H. Harris		46. NAME OF WITNESS J. H. Harris		47. NAME OF WITNESS J. H. Harris		48. NAME OF WITNESS J. H. Harris	
49. NAME OF WITNESS J. H. Harris		50. NAME OF WITNESS J. H. Harris		51. NAME OF WITNESS J. H. Harris		52. NAME OF WITNESS J. H. Harris	
53. NAME OF WITNESS J. H. Harris		54. NAME OF WITNESS J. H. Harris		55. NAME OF WITNESS J. H. Harris		56. NAME OF WITNESS J. H. Harris	
57. NAME OF WITNESS J. H. Harris		58. NAME OF WITNESS J. H. Harris		59. NAME OF WITNESS J. H. Harris		60. NAME OF WITNESS J. H. Harris	
61. NAME OF WITNESS J. H. Harris		62. NAME OF WITNESS J. H. Harris		63. NAME OF WITNESS J. H. Harris		64. NAME OF WITNESS J. H. Harris	
65. NAME OF WITNESS J. H. Harris		66. NAME OF WITNESS J. H. Harris		67. NAME OF WITNESS J. H. Harris		68. NAME OF WITNESS J. H. Harris	
69. NAME OF WITNESS J. H. Harris		70. NAME OF WITNESS J. H. Harris		71. NAME OF WITNESS J. H. Harris		72. NAME OF WITNESS J. H. Harris	
73. NAME OF WITNESS J. H. Harris		74. NAME OF WITNESS J. H. Harris		75. NAME OF WITNESS J. H. Harris		76. NAME OF WITNESS J. H. Harris	
77. NAME OF WITNESS J. H. Harris		78. NAME OF WITNESS J. H. Harris		79. NAME OF WITNESS J. H. Harris		80. NAME OF WITNESS J. H. Harris	
81. NAME OF WITNESS J. H. Harris		82. NAME OF WITNESS J. H. Harris		83. NAME OF WITNESS J. H. Harris		84. NAME OF WITNESS J. H. Harris	
85. NAME OF WITNESS J. H. Harris		86. NAME OF WITNESS J. H. Harris		87. NAME OF WITNESS J. H. Harris		88. NAME OF WITNESS J. H. Harris	
89. NAME OF WITNESS J. H. Harris		90. NAME OF WITNESS J. H. Harris		91. NAME OF WITNESS J. H. Harris		92. NAME OF WITNESS J. H. Harris	
93. NAME OF WITNESS J. H. Harris		94. NAME OF WITNESS J. H. Harris		95. NAME OF WITNESS J. H. Harris		96. NAME OF WITNESS J. H. Harris	
97. NAME OF WITNESS J. H. Harris		98. NAME OF WITNESS J. H. Harris		99. NAME OF WITNESS J. H. Harris		100. NAME OF WITNESS J. H. Harris	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10410

CERTIFICATE OF DEATH

10390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12013 Grandview Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rauline Rao Puglisi</u>				4. DATE OF DEATH Month Day Year <u>Sept 15 1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 14, 1899</u>	
9. AGE (In years last birthday) yrs. <u>59</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furs</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>				13. FATHER'S NAME <u>Lorenzo Rao</u>			
14. MOTHER'S MAIDEN NAME <u>Grace Puglisi</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>577-18-4588</u>				17. INFORMANT Address <u>Pasquale Puglisi 12013 Grandview Ave. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor - Metastatic</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral carcinoma of the breast</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Nov. 1950</u> , 19____, to <u>Sept 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 14</u> , 19 <u>58</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene A. Forcione</u> M.D.				ADDRESS (Street, city or town, state) <u>2100 Conn. Ave., N.W., Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>EUGENE A. FORCIONE</u>				DATE SIGNED <u>9/15/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>		22b. DATE THEREOF <u>9/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN MAUSOLEUM</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Raymond A. Juska, SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 18 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10391

10411

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8434 GEORGIA AVENUE			d. STREET ADDRESS 1600 EAST WEST HIGHWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) WARNER EDWARD PUMPHREY			4. DATE OF DEATH Month SEPTEMBER Day 7 Year 1958		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 14, 1896	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) funeral director		10b. KIND OF BUSINESS OR INDUSTRY funeral		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME WILLIAM REUBEN PUMPHREY		
14. MOTHER'S MAIDEN NAME HARRIET A. Shekell			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW #1		
16. SOCIAL SECURITY NO. 218-24-3291		17. INFORMANT Edna C. Pumphrey, 1600 East-West Highway, SS., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ARLINGTON, VIRGINIA	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Sept. 7, 1958	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/10/58	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond H. Ziska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 9 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10412

CERTIFICATE OF DEATH

Reg. Dist. No.

10392
215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY a. a.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 mos. 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. STREET ADDRESS 87 College Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Walter Middle Emil Last QUENSTEDT		4. DATE OF DEATH Month September Day 10 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 March 1890		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Quenstedt				14. MOTHER'S MAIDEN NAME Alberta Crouse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT (Wife) Mrs. May L. Quenstedt (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lung with Metastases 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH About 6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 June , 19 58 , to 10 Sept. , 19 58 , that I last saw the deceased alive on 10 Sept. , 19 58 , and that death occurred at 12:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. U. Shilling U.S. Naval Hospital, Bethesda, Md. 9-10-58							
ACTUAL SIGNATURE		M.D. U.S. Naval Hospital, Bethesda, Md. 9-10-58					
PHYSICIAN'S NAME (Type)		C. U. SHILLING, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-15-58		22c. NAME OF CEMETERY OR CREMATORY Academy Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. M. Taylor		ADDRESS 147 Gloucester St. Annapolis, Md.		24a. REC'D BY REGISTRAR SEP 19 58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1947

10413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u> <u>R.F.D.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>mnty Co. Gen Hosp</u>			d. STREET ADDRESS <u>Unity Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ralph A. Reese</u>			4. DATE OF DEATH <u>Sept 1 1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 9 1934</u>		9. AGE (in years last birthday) <u>23</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>gas station</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Vilctus Reese</u>			14. MOTHER'S MAIDEN NAME <u>Nancy McDaniel</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Estela Reese</u> Address <u>R-2 Gaithersburg md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>drowning</u> DUE TO (c) <u>auto accident</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was driven from that missed bridge & overturned in Potomac R.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>5:35</u> a.m. <u>9-1</u> 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hwy R-97</u>	
20f. (City or town) <u>Mr. Sunshine Monty</u>		(County) <u>md</u>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FLANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Liberty Baptist</u>	
22d. LOCATION (City, town, or county) <u>Lisbon, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u> ADDRESS <u>Laytonville, Md.</u>			24a. REC'D BY REGISTRAR <u>SEP 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10291

CERTIFICATE OF DEATH

10394

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 259 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3				d. STREET ADDRESS 4216 YUMA ST., N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle DEE Last RICHARDSON				4. DATE OF DEATH Month SEPTEMBER Day 30 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-14-00	
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months 2 Days 11 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Information Sp.				10b. KIND OF BUSINESS OR INDUSTRY Dept. of Defense		11. BIRTHPLACE (State or foreign country) Oregon	
13. FATHER'S NAME James Green Richardson				14. MOTHER'S MAIDEN NAME Maudie Hughes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chart Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Broncho Pneumonia							
INTERVAL BETWEEN ONSET AND DEATH 1 year							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/14 , 19 58 , to September 29 , 19 58 , that I last saw the deceased alive on September 29 , 19 58 , and that death occurred at 3:07 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1216 16th St. N.W. G.D.C. DATE SIGNED 9/30/58							
ACTUAL SIGNATURE Albert E. Marland, Jr. M.D. 1216 16th St. N.W. G.D.C.							
PHYSICIAN'S NAME (Type) Albert E Marland, Jr. 1216 16th St. N. W. Wash. 6, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/2/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Phamph...				24a. REC'D BY REGISTRAR DATE OCT 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10292

CERTIFICATE OF DEATH

10396

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 5½ months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 ALBANY AVENUE				e. STREET ADDRESS 711 ORCHARD WAY			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANNIE Middle BURCH Last RILEY				4. DATE OF DEATH Month SEPT. Day 15 Year 19 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/11/76	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME G. MORTIMER CECIL				14. MOTHER'S MAIDEN NAME SARAH J. BURCH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Edgar L. Burch, 711 Orchard Way Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROSIS & HYPERTENSION INTERVAL BETWEEN ONSET AND DEATH 9 months 4 years 7 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April , 19 54 , to Sept 15 , 19 58 , that I last saw the deceased alive on Sept 13 , 19 58 , and that death occurred at 12:57 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Neil P. Campbell				ADDRESS (Street, city or town, state) Kenesaw Apt			
PHYSICIAN'S NAME (Type) Neil P. Campbell				DATE SIGNED 9/15/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/18/58		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 17 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbels. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10397

10414

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church		d. STREET ADDRESS 541 Belleview Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Donald Middle Dennis Last ROSCH		4. DATE OF DEATH Month Sept. Day 19 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Sept. 1958
9. AGE (In years last birthday) yrs. 6		IF UNDER 1 YEAR Months 6 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Leon ROSCH		14. MOTHER'S MAIDEN NAME Jeanne Evelyn MAC LELLAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Leon ROSCH (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacteraemia, organism E. coli. 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) multiple congenital anomalies DUE TO (c) 6 days INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 Sept. 19 58 , to 19 Sept. 19 58 , that I last saw the deceased alive on 19 Sept. 19 58 , and that death occurred at 11:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md.			
ACTUAL SIGNATURE Bethesda per Dr. Harris		PHYSICIAN'S NAME (Type) F. De PAOLA LT MC USN U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-23-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l CEMETERY		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ARLINGTON Funeral Home		24a. REC'D BY REGISTRAR SEP 23 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

2051352 XV3

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10415

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia D. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 19 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. STREET ADDRESS 1606 "W" Street, S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Betty Middle Mae Last SARGENT				4. DATE OF DEATH Month September Day 17 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 November 1937	
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months 20 Days 20 Hours 20 Min.		IF UNDER 24 HRS. Months 20 Days 20 Hours 20 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Johnny Freeman BENTON				14. MOTHER'S MAIDEN NAME Mary Elizabeth LASTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) Richard John SARGENT (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pyelonephritis with abscess formation and papillary necrosis, bilateral 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 29 August, 19 58 , to 17 Sept., 19 58 , that I last saw the deceased alive on 17 Sept., 19 58 , and that death occurred at 9:26 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C.R. Boyce				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
DATE SIGNED 9-18-58							
PHYSICIAN'S NAME (Type) C.R. BOYCE, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-58		22c. NAME OF CEMETERY OR CREMATORY Weldon Cemetery		22d. LOCATION (City, town, or county) (State) Weldon, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				24a. REC'D BY REGISTRAR SEP 23 '58			
ADDRESS R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.				24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
15M 10/57

10416 Item #13414 to form B 423 462/70 JTB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10399

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)	c. LENGTH OF STAY IN 1b 42 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 1615.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH NMC Bethesda, Maryland		d. STREET ADDRESS Rockville Pike	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Emma Middle Elizabeth Last SCHMULOVITZ		4. DATE OF DEATH Month September Day 6 Year 19 58	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 13, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME JOHN F. TALBERT <i>George Collard</i>		14. MOTHER'S MAIDEN NAME ANNIE GENGRODT <i>A. Gengerodt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT MRS JOSEPHINE GELFO 6524 8th Ave Ray Park, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Multiple Cerebral Vascular Accidents 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Peripheral Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Carcinoma, Breast with Metastasis			INTERVAL BETWEEN ONSET AND DEATH Jul 27, 1958
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 6:55 p. m. Sep 6 19 58		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jul 27, 19 58 to Sep 6, 19 58 , that I last saw the deceased alive on Sep 6, 19 58 , and that death occurred at 1855P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. J. JACOBY, Jr.		ADDRESS (Street, city or town, state) USNH, NMC, Bethesda, Md. DATE SIGNED Sep 7, 1958	
PHYSICIAN'S NAME (Type) W. J. JACOBY Jr.		USNH, NMC, Bethesda, Md. Sep 7, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Sep 19, 1958	22c. NAME OF CEMETERY OR CREMATORY Congressional Wash., D.C.	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Jacoby Jr.</i>		ADDRESS D.C.	24a. REC'D BY REGISTRAR 10 58
		24b. REGISTRAR'S SIGNATURE <i>Carlton E. French</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH-19

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1920		Baltimore, Md.	
Cause of Death		Disease		Organ		Manner		Occupation	
Heart Disease		Coronary Artery		Heart		Natural		None	
Time of Death		Place of Burial		Name of Minister		Name of Undertaker		Name of Physician	
10:00 AM		St. Paul's Church		Rev. J. Smith		J. Brown		Dr. C. White	
Signature of Physician		Signature of Minister		Signature of Undertaker		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 39 days		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Indiana b. COUNTY 52x-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 322 East 15th Street							
3. NAME OF DECEASED (Type or print) First Edwin Middle Richard Last Schutz		4. DATE OF DEATH Month September Day 14, Year 19 58							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1919	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months 39	IF UNDER 24 HRS. Days 39	Hours 39	Min. 39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Superintendent		10b. KIND OF BUSINESS OR INDUSTRY City Government		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Edward Schutz		14. MOTHER'S MAIDEN NAME Augusta Tretter							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Respiratory failure 173x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). Choriocarcinoma with pulmonary metastases DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastases to brain, liver, thyroid and pancreas								INTERVAL BETWEEN ONSET AND DEATH 4 Weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) September 14, 19 58		(County) (State)	
21. I certify that I attended the deceased from August 6, 19 58 to September 14, 19 58 , that I last saw the deceased alive on September 14, 19 58 , and that death occurred at 8:00 A M, from the causes and on the date stated above.									
ACTUAL SIGNATURE Richard H. Moy		M.D. The Clinical Center		ADDRESS (Street, city or town, state) The National Institutes of Health		DATE SIGNED 9-14-58			
PHYSICIAN'S NAME (Type) Richard H. Moy, M. D.				Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 9-14-58		22b. DATE THEREOF 9-14-58		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) Dubois County, Indiana		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

10418

CERTIFICATE OF DEATH

10401

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Alabama b. COUNTY Phenix City e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Randolph Middle (none) Last Scott		4. DATE OF DEATH Month September Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 14, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) yrs. 9 Months 21 Days Hours Min.
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Scott		14. MOTHER'S MAIDEN NAME Albertha Bell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital transverse arteriosus and interventricular septal defect 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac arrest, post-operative pulmonary artery DUE TO (c) acute congestion: lungs, liver, spleen, kidneys			INTERVAL BETWEEN ONSET AND DEATH 11 hours post-op. hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 24, 1958 to September 5, 1958 , that I last saw the deceased alive on September 5, 1958 , and that death occurred at 11:20 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert S. Bloodwell M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/7/58	
PHYSICIAN'S NAME (Type) ROBERT S. BLOODWELL, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/11/58	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Columbus, Ga.
23. FUNERAL DIRECTOR'S SIGNATURE Johnson + Jenkin Funeral Home ADDRESS 4804 GA. Ave N.W.		24a. REC'D BY REGISTRAR SEP 15 '58	24b. REGISTRAR'S SIGNATURE Charles S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10402

10298

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>6 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12917 Parkland Dr</u>						d. STREET ADDRESS <u>12917 Parkland Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Antonino Scuderi</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>24</u> Year <u>1958</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-1-94</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Car repairman retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Scarmelo Scuderi</u>				14. MOTHER'S MAIDEN NAME <u>Rose NUNNIA TRIXILETTI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>718-14-9114</u>		17. INFORMANT <u>Rose Scuderi</u>		Address <u>Itin 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardio-vascular disease</u> DUE TO (c) _____</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>12 yrs.</u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Sept 24 - 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hauer</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10238

FOR STATE

DEATH

NAME OF DECEASED <i>John J. [illegible]</i>		AGE <i>45</i>		SEX <i>Male</i>	
DATE OF DEATH <i>Jan 15 1923</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>	
RESIDENCE <i>1234 [illegible] St. Baltimore, Md.</i>		OCCUPATION <i>Engineer</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		SIGNATURE OF EXAMINER <i>[illegible]</i>	
DATE OF EXAMINATION <i>Jan 15 1923</i>		TIME OF EXAMINATION <i>11:00 AM</i>		PLACE OF EXAMINATION <i>Home</i>	
SIGNATURE OF DECEASED <i>[illegible]</i>		SIGNATURE OF WITNESS <i>[illegible]</i>		SIGNATURE OF EXAMINER <i>[illegible]</i>	
DATE OF SIGNATURE <i>Jan 15 1923</i>		TIME OF SIGNATURE <i>11:00 AM</i>		PLACE OF SIGNATURE <i>Home</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10419

10403

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 63 hrs. 23 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Friendship 13 X-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle - Last Selby				4. DATE OF DEATH Month September Day 5 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/3/58	
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months 23		IF UNDER 24 HRS. Days 63 Mins. 23			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John E. Selby, Sr.				14. MOTHER'S MAIDEN NAME Hilda M. Affeldt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Sept. 3 , 19 58 , to Sept. 5 , 19 58 , that I last saw the deceased alive on Sept. 5 , 19 58 , and that death occurred at 2:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED Sept. 5, 1958							
ACTUAL SIGNATURE C. S. Whitaker M.D. _____				PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D. Clarksville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 5, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		22d. LOCATION (City, town, or county) Ellicott City, Md. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons ADDRESS Catonsville, Md.				24a. REC'D BY REGISTRAR DATE SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073222XVI

CERTIFICATE OF DEATH

1921

Name of Deceased		John J. Smith	
Age		67 years, 24 days	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Carpenter	
Residence		Baltimore, Maryland	
Cause of Death		Heart Disease	
Date of Death		April 15, 1921	
Place of Death		Home	
Physician		Dr. J. H. Jones	
Burial Place		St. Mary's Cemetery	
Burial Date		April 17, 1921	
Signature of Physician		J. H. Jones	
Signature of Registrar		J. H. Jones	
Signature of Coroner		J. H. Jones	
Signature of Medical Examiner		J. H. Jones	
Signature of Health Officer		J. H. Jones	
Signature of County Clerk		J. H. Jones	
Signature of State Registrar		J. H. Jones	

CERTIFICATE OF DEATH

Reg. Dist. No.

10404

10420

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5620 Southwick St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRA Middle S. Last SHANTZ		4. DATE OF DEATH Month Sept. Day 11, Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1879
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 11 Days 29	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Printing		10b. KIND OF BUSINESS OR INDUSTRY Government	11. BIRTHPLACE (State or foreign country) Baden, Ontario, Canada
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Christian Shantz	
14. MOTHER'S MAIDEN NAME Nancy Steiner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 578-05-4069		17. INFORMANT (Wife) Gladys B. Shantz Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerosis generalized DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 5 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October, 1953 , to Sept 11, 1958 , that I last saw the deceased alive on Sept. 11, 1958 , and that death occurred at 12 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4711 Highland Ave., Bethesda, Md. DATE SIGNED 9-12-58			
ACTUAL SIGNATURE Alfred S. Norton M.D.		PHYSICIAN'S NAME (Type) ALFRED S. NORTON	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-13-58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Prince George Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE SEP 16 58	24b. REGISTRAR'S SIGNATURE Wm. S. Thoms

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10421

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>50 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				e. STREET ADDRESS <u>13229 Medway St.</u>			
3. NAME OF DECEASED (Type or print) <u>Betta Marguerite Shaw</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 31, 1884</u>	
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Levi Gephart</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Geon Harris 3229 Medway St. Lb.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis (Repeated CVA's)</u> DUE TO (c) <u>unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>9 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5 Sept</u> , 19 <u>58</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11602 Georgia Ave Silver Spring Md.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Morris Perry</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Morris Perry</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10406

10422

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 606 No. Horners Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Francis Last Shelton				4. DATE OF DEATH Month September Day 21 Year 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1911		9. AGE (In years last birthday) yrs. 46	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Naval Medical Center		11. BIRTHPLACE (State or foreign country) Rockville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Shelton				14. MOTHER'S MAIDEN NAME Maggie Wood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Wife Address Lucinda Shelton As above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Wernia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Arteriosclerosis (c) Hypertensive C-V Disease							INTERVAL BETWEEN ONSET AND DEATH 2 wks 1 yr 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Mar. 1, 1958 to 9/21, 1958 , that I last saw the deceased alive on 9/21, 1958 , and that death occurred at 3:05 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen N. Jones				ADDRESS (Street, city or town, state) Rockville, Md		DATE SIGNED 9/21/58	
PHYSICIAN'S NAME (Type) Stephen N. Jones							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/58		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park,		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R.L. Snowden				ADDRESS Rockville, Md		24a. REC'D BY REGISTRAR DATE SEP 24 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hase			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
SALES MAN		HEART DISEASE		SUICIDE		HOME		JAN 30 1968	
PREVIOUS ILLNESS		SIGNS AND SYMPTOMS		TREATMENT		POST MORTEM		BURIAL	
NONE		PAIN IN CHEST		NO		NO		NONE	
DATE OF EXAMINATION		BY		TITLE		HOSPITAL		CITY	
JAN 30 1968		J. H. SMITH		M.D.		ST. JOSEPH'S		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 30 1968		JAN 30 1968		JAN 30 1968		JAN 30 1968		JAN 30 1968	

10423

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9200 Old Georgetown Rd.				d. STREET ADDRESS Dodge Hotel			
3. NAME OF DECEASED (Type or print) First Lytle Middle Gordon Last Shuck, Sr.				4. DATE OF DEATH Month Sept Day 16 Year 1958			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1895	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Govt Print. Office		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt		11. BIRTHPLACE (State or foreign country) Grafton, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter Shuck				14. MOTHER'S MAIDEN NAME Minerva E. Sieff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs Ilda J. Shuck. (wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO Metastatic SARCOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) PRIMARY SITE Undetermined (c)						INTERVAL BETWEEN ONSET AND DEATH? ONE YR?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 1947 to SEPT 10 , 19 58 , that I last saw the deceased alive on SEPT 7 , 19 58 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dewitt E. DeLawter M.D.				ADDRESS (Street, city or town, state) 8025 ABERDEEN Rd		DATE SIGNED 9/10/58	
PHYSICIAN'S NAME (Type) Dewitt E. DeLawter				Bethesda 14, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF Sept. 13, 1958	22c. NAME OF CEMETERY OR CREMATORY Lees Crematorium		22d. LOCATION (City, town, or county) (State) Washington D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Sanders				ADDRESS 300 N. 4th St N.E.		24a. REC'D BY REGISTRAR DATE SEP 15 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18&21 Film 233 9-15-58

10424

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10408

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 1 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 703 Dale Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louise Wetherill Slack, M.D.		4. DATE OF DEATH Sept. 8 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-1908
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Slack		14. MOTHER'S MAIDEN NAME Maud Wetherall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW #2	
17. INFORMANT John B. Slack, III - 703 Dale Drive		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Parbiturate poisoning 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Found Dead on bedroom floor of home	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Trans. & Burial		22b. DATE THEREOF 9/11/58	
22c. NAME OF CEMETERY OR CREMATORY Woodlane Cemetery		22d. LOCATION (City, town, or county) (State) Burlington County, N. J.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR SEP 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

Fineall Co.
Baitbury

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10425

CERTIFICATE OF DEATH

10409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Batchellors Forest Road, Olney	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharon Nursing Home		d. STREET ADDRESS XXXXXXXXXXXXXXXXXXXX	
3. NAME OF DECEASED (Type or print) JOHANNA First Middle Last H. SLYE		4. DATE OF DEATH Month Sept. Day 22 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/1869
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Home Records - Olney, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion - Myocardial 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarct - Far Advanced DUE TO (c) Arteriosclerotic Cardiovascular		INTERVAL BETWEEN ONSET AND DEATH 3 days 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 Sept , 19 58 , to 22 Sept , 19 58 , that I last saw the deceased alive on 21 Sept , 19 58 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Ziegler		ADDRESS (Street, city or town, state) OLNEY, MD	
PHYSICIAN'S NAME (Type) JOHN B. ZIEGLER		DATE SIGNED 22 Sept 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/58	
22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.		ADDRESS Wash. D.C.	
24a. REC'D BY REGISTRAR SEP 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10426

CERTIFICATE OF DEATH

Reg. Dist. No. 10410

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4317 Center St.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELFIE</u> Middle <u>CYRENA</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept., 13, 1875</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Eben Smith Wright</u>		14. MOTHER'S MAIDEN NAME <u>Kathryn Hulbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Miss Mildred Kathryn Smith, Chevy Chase, Md.</u>		Address <u>4317 Center St., Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thromboses, multiple</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general, severe</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>12 yrs +</u> <u>12 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>---</u> Day <u>19</u> Hour a. m. <u>---</u> p. m. <u>---</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1946</u> , to <u>Sept 14, 1958</u> , that I last saw the deceased alive on <u>Sept 12, 1958</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar St. Wash 15 DC</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		DATE SIGNED <u>9.14.58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>9/17/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Tray 22</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home, Chevy Chase, Md.</u>		24a. REGD BY REGISTRAR <u>SEP 16 58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 14, Film G234, 10/6/58

10293

CERTIFICATE OF DEATH

Reg. Dist. No.

10411

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 2 da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital				e. STREET ADDRESS 1440 Univ. Blvd.			
3. NAME OF DECEASED (Type or print) First Overton Middle Jeter Last Smith				4. DATE OF DEATH Month 9 Day 23 Year 1958			
5. SEX m	6. COLOR OR RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-88	9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street oper.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	12. CITIZEN OF WHAT COUNTRY? h-amer.
13. FATHER'S NAME Kirby Smith				14. MOTHER'S MAIDEN NAME Hattie K. William			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 578-10-7585		17. INFORMANT Hospital records. Address 7600 Carroll Ave T.P. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHIOGENIC CARCINOMA DUE TO (c) WITH METASTASES INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 6 mos +							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIO SCLEROSIS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/11 , 19 58 , to 9/23 , 19 58 , that I last saw the deceased alive on 9/22 , 19 58 , and that death occurred at 4:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE David Steiner				ADDRESS (Street, city or town, state) 1352 University Lane, Hyattsville			
PHYSICIAN'S NAME (Type) David Steiner				DATE-SIGNED SEP 25 '58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/58		22c. NAME OF CEMETERY OR CREMATORY Antioch Church		22d. LOCATION (City, town, or county) (State) RM Guinea Mills Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons				ADDRESS 4739 Balto. Ave. Hyattsville, Md.		24. REC'D BY REGISTRAR DATE SEP 25 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10294

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Philadelphia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> 75x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>1527 Louden ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>ETTA</u> Middle <u>Heller</u> Last <u>STAMM</u>				4. DATE OF DEATH Month <u>9</u> Day <u>-22</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-FO</u>	9. AGE (In years last birthday) <u>77</u> yrs.	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>22</u> Hours <u>12</u> Min.		11. IF UNDER 24 HRS. Months <u>7</u> Days <u>22</u> Hours <u>12</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Louis KOTZ</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Heller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hospital Records</u> Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) <u>Patent myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-21</u> , 19 <u>58</u> , to <u>9-22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-22</u> , 19 <u>58</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Abraham W. Danish</u>				ADDRESS (Street, city or town, state) <u>927 PERSHING DR.</u> DATE SIGNED <u>9-22-58</u>			
PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>				SILVER SPRING, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal & cremation</u>		22b. DATE THEREOF <u>9/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chelton Hills Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond W. Juska</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 12-100

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1890</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>11-10-1950</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Immediate cause: <u>MYOCARDIAL INFARCTION</u></p>	
<p>9. Duration of illness: <u>2 WEEKS</u></p>		<p>10. Usual place of abode: <u>HOME</u></p>	
<p>11. Name of attending physician: <u>DR. J. H. SMITH</u></p>		<p>12. Name of medical examiner: <u>DR. J. H. SMITH</u></p>	
<p>13. Name of funeral home: <u>JOHN J. SMITH</u></p>		<p>14. Name of cemetery: <u>GREENWOOD</u></p>	
<p>15. Name of informant: <u>JOHN J. SMITH</u></p>		<p>16. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>17. Name of informant: <u>JOHN J. SMITH</u></p>		<p>18. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>19. Name of informant: <u>JOHN J. SMITH</u></p>		<p>20. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>21. Name of informant: <u>JOHN J. SMITH</u></p>		<p>22. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>23. Name of informant: <u>JOHN J. SMITH</u></p>		<p>24. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>25. Name of informant: <u>JOHN J. SMITH</u></p>		<p>26. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>27. Name of informant: <u>JOHN J. SMITH</u></p>		<p>28. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>29. Name of informant: <u>JOHN J. SMITH</u></p>		<p>30. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>31. Name of informant: <u>JOHN J. SMITH</u></p>		<p>32. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>33. Name of informant: <u>JOHN J. SMITH</u></p>		<p>34. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>35. Name of informant: <u>JOHN J. SMITH</u></p>		<p>36. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>37. Name of informant: <u>JOHN J. SMITH</u></p>		<p>38. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>39. Name of informant: <u>JOHN J. SMITH</u></p>		<p>40. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>41. Name of informant: <u>JOHN J. SMITH</u></p>		<p>42. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>43. Name of informant: <u>JOHN J. SMITH</u></p>		<p>44. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>45. Name of informant: <u>JOHN J. SMITH</u></p>		<p>46. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>47. Name of informant: <u>JOHN J. SMITH</u></p>		<p>48. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>49. Name of informant: <u>JOHN J. SMITH</u></p>		<p>50. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>51. Name of informant: <u>JOHN J. SMITH</u></p>		<p>52. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>53. Name of informant: <u>JOHN J. SMITH</u></p>		<p>54. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>55. Name of informant: <u>JOHN J. SMITH</u></p>		<p>56. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>57. Name of informant: <u>JOHN J. SMITH</u></p>		<p>58. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>59. Name of informant: <u>JOHN J. SMITH</u></p>		<p>60. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>61. Name of informant: <u>JOHN J. SMITH</u></p>		<p>62. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>63. Name of informant: <u>JOHN J. SMITH</u></p>		<p>64. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>65. Name of informant: <u>JOHN J. SMITH</u></p>		<p>66. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>67. Name of informant: <u>JOHN J. SMITH</u></p>		<p>68. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>69. Name of informant: <u>JOHN J. SMITH</u></p>		<p>70. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>71. Name of informant: <u>JOHN J. SMITH</u></p>		<p>72. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>73. Name of informant: <u>JOHN J. SMITH</u></p>		<p>74. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>75. Name of informant: <u>JOHN J. SMITH</u></p>		<p>76. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>77. Name of informant: <u>JOHN J. SMITH</u></p>		<p>78. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>79. Name of informant: <u>JOHN J. SMITH</u></p>		<p>80. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>81. Name of informant: <u>JOHN J. SMITH</u></p>		<p>82. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>83. Name of informant: <u>JOHN J. SMITH</u></p>		<p>84. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>85. Name of informant: <u>JOHN J. SMITH</u></p>		<p>86. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>87. Name of informant: <u>JOHN J. SMITH</u></p>		<p>88. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>89. Name of informant: <u>JOHN J. SMITH</u></p>		<p>90. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>91. Name of informant: <u>JOHN J. SMITH</u></p>		<p>92. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>93. Name of informant: <u>JOHN J. SMITH</u></p>		<p>94. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>95. Name of informant: <u>JOHN J. SMITH</u></p>		<p>96. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>97. Name of informant: <u>JOHN J. SMITH</u></p>		<p>98. Name of informant: <u>JOHN J. SMITH</u></p>	
<p>99. Name of informant: <u>JOHN J. SMITH</u></p>		<p>100. Name of informant: <u>JOHN J. SMITH</u></p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10412

10427

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montgomery		STATE Maryland COUNTY Montgomery		CITY (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		CITY (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
CITY OR TOWN Germantown		LENGTH OF STAY (in this place) 3 Years		CITY OR TOWN Gaithersburg		CITY OR TOWN Gaithersburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Marylander Home		STREET ADDRESS H.F.D. I		STREET ADDRESS H.F.D. I		STREET ADDRESS H.F.D. I	
3. NAME OF DECEASED (Type or Print) Katherine C. Sutliff				4. DATE OF DEATH (Month) Sept (Day) 5 (Year) 19 58			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 23 1878	9. AGE last birthday 79 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Micheal E. Carley				14. MOTHER'S MAIDEN NAME Marie C. Fleming			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Vinoent Sutliff		18. AS Same	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) ACUTE CONGESTIVE HEART FAILURE				INTERVAL BETWEEN ONSET AND DEATH 24 HRS.			
ANTECEDENT CAUSE(S) DUE TO (B) ARTERIO-SCLEROTIC HEART DISEASE				20 YRS.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) ESSENTIAL HYPERTENSION				25 YRS.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. MULTIPLE CEREBRO-VASCULAR ACCIDENTS				4 YRS.			
DIVERTICULITIS, CHRONIC				8 YRS.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT. 5, 1958</u>, to <u>SEPT. 5, 1958</u>, that I last saw the deceased alive on <u>SEPT. 5, 1958</u>, and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE Raumur S. Donnelly				DATE SIGNED 1827 23RD ST. N.W. WASH DC 9/5/58			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Sept 8, 58		NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		LOCATION (City, town, or county) (State) Flushing New York	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Arthur S. Kincaid		25. FUNERAL DIRECTOR'S SIGNATURE Raymond Barber		ADDRESS Laytonsville, Md.	
DATE SEP 8 '58							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10428

CERTIFICATE OF DEATH

10414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Phillip Last Sutphin				4. DATE OF DEATH Month September Day 14 Year 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1893	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Sutphin				14. MOTHER'S MAIDEN NAME Molly Sutphin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Septicemia DUE TO 2043 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Staphylococcal Bacteraemia (c) Acute Leukemia						INTERVAL BETWEEN ONSET AND DEATH 3-4 days " " approx 8 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 19 58 to September 14 58 , that I last saw the deceased alive on September 14 58 , and that death occurred at 3:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland DATE SIGNED 9/15/58							
ACTUAL SIGNATURE Leonard Garren		M.D. The National Institutes of Health					
PHYSICIAN'S NAME (Type) Leonard Garren, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR SEP 22 58		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

CERTIFICATE OF DEATH

10038

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES M. JONES		Male		35		1915		Maryland		Baltimore		Maryland		United States	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
10/15/1950		10:30 AM		Home		Heart Disease		Natural		Coronary Artery Disease		Chest Pain, Shortness of Breath		Medication, Rest	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Teacher		High School		Married		Catholic		White		White		Brown		Blue	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER		PREVIOUS OTHER	
None		None		None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF JURY	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	
DATE		TIME		PLACE		CAUSE		MANNER		DISEASE		SYMPTOMS		TREATMENT	
10/15/1950		10:30 AM		Home		Heart Disease		Natural		Coronary Artery Disease		Chest Pain, Shortness of Breath		Medication, Rest	

RECEIVED
BALTIMORE
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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10425 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10415

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7802 Tomlinson Ave</u>			d. STREET ADDRESS <u>7802 Tomlinson Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Alonzo Morgan Thomas Jr</u>			4. DATE OF DEATH <u>Sept 1 1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-1913</u>		9. AGE (In years last birthday) <u>45 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. GOVT.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Alonzo M. Thomas</u>			14. MOTHER'S MAIDEN NAME <u>Selma Wendt</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WW 2</u>		17. INFORMANT <u>Selma Thomas (Mother)</u> Address <u>Stn 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Bruschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-1-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/4/58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	
				23d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			
24c. REGISTRAR'S SIGNATURE					

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				10416	
Item 3, Film G-234 9/26/58.cac.					
10430				CERTIFICATE OF DEATH	
Reg. Dist. No. 215					
1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1524 Potomac Ave., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elise "S" THOMPSON		4. DATE OF DEATH Month Day Year September 14 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3 Sept. 1884		9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Norway	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Soren ANDERSEN		14. MOTHER'S MAIDEN NAME Ellen ANDERSEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) Axel K. THOMPSON (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170x Adenocarcinoma, Left Breast with Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Undetermined			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 23 August, 19 58, to 14 Sept., 19 58, that I last saw the deceased alive on 14 Sept., 19 58, and that death occurred at 11:00 P.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE Burt C. Johnson		M.D.		U.S. Naval Hospital, Bethesda, Md. 9-15-58	
PHYSICIAN'S NAME (Type) Burt C. Johnson, LCDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-18-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) Suitland, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, 4th & Mass Ave., N.W. Wash.D.C.		ADDRESS		24a. REC'D BY REGISTRAR SEP 19 58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hana					

MAST AND STATE DEPARTMENT OF HEALTH—ALABAMA

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10417

10431

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norbeck</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomena's Rest Home</u>		d. STREET ADDRESS <u>1604 Michigan Ave. N.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>K.</u> Last <u>Towles</u>		4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/8, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk Ret. Inesstate Come Govern.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. B.</u>	
11. BIRTHPLACE (State or foreign country) <u>Elkins N. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William L. Kee</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Pherris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Lawrence E. Towles</u> Address <u>1604 Mich Ave Wash. D.C. NE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiovascular disease</u> <u>442X</u> DUE TO <u>Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5 June 58</u> to <u>7 Sept 58</u> , that I last saw the deceased alive on <u>31 Aug 58</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. Haile</u> M.D. <u>55 M. Ave. N.W.</u>		DATE SIGNED <u>9/17/58</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. HAILE</u>		<u>135-N. Y. Ave. N.W. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>mt. Rainier Md</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home</u> Address <u>mt. Rainier Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 11 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1923

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 15 1923</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. DISEASE OR INJURY <i>Myocardial Infarction</i></p>		<p>9. MANNER OF DEATH <i>Natural</i></p>	
<p>10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>11. SIGNATURE OF WITNESSES <i>John Doe, Jr.</i></p>		<p>12. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>13. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>14. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>15. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>16. SIGNATURE OF JURY <i>John Doe</i></p>		<p>17. SIGNATURE OF JURY <i>John Doe</i></p>		<p>18. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>19. SIGNATURE OF JURY <i>John Doe</i></p>		<p>20. SIGNATURE OF JURY <i>John Doe</i></p>		<p>21. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>22. SIGNATURE OF JURY <i>John Doe</i></p>		<p>23. SIGNATURE OF JURY <i>John Doe</i></p>		<p>24. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>25. SIGNATURE OF JURY <i>John Doe</i></p>		<p>26. SIGNATURE OF JURY <i>John Doe</i></p>		<p>27. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>28. SIGNATURE OF JURY <i>John Doe</i></p>		<p>29. SIGNATURE OF JURY <i>John Doe</i></p>		<p>30. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>31. SIGNATURE OF JURY <i>John Doe</i></p>		<p>32. SIGNATURE OF JURY <i>John Doe</i></p>		<p>33. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>34. SIGNATURE OF JURY <i>John Doe</i></p>		<p>35. SIGNATURE OF JURY <i>John Doe</i></p>		<p>36. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>37. SIGNATURE OF JURY <i>John Doe</i></p>		<p>38. SIGNATURE OF JURY <i>John Doe</i></p>		<p>39. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>40. SIGNATURE OF JURY <i>John Doe</i></p>		<p>41. SIGNATURE OF JURY <i>John Doe</i></p>		<p>42. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>43. SIGNATURE OF JURY <i>John Doe</i></p>		<p>44. SIGNATURE OF JURY <i>John Doe</i></p>		<p>45. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>46. SIGNATURE OF JURY <i>John Doe</i></p>		<p>47. SIGNATURE OF JURY <i>John Doe</i></p>		<p>48. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>49. SIGNATURE OF JURY <i>John Doe</i></p>		<p>50. SIGNATURE OF JURY <i>John Doe</i></p>		<p>51. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>52. SIGNATURE OF JURY <i>John Doe</i></p>		<p>53. SIGNATURE OF JURY <i>John Doe</i></p>		<p>54. SIGNATURE OF JURY <i>John Doe</i></p>	
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1. NAME OF DECEASED
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3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CAUSE OF DEATH
8. DISEASE OR INJURY
9. MANNER OF DEATH
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF WITNESSES
12. SIGNATURE OF DECEASED
13. SIGNATURE OF REGISTRAR
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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10418

Reg. Dist. No.

10432

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>X</u> <u>Bethesda</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9938 Mayfield Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BETTYE</u> <u>JO</u> <u>TREMME</u>		4. DATE OF DEATH <u>Sept. 23, 1958</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1922</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR <u>1</u> Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Joseph B. Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Ailley C. Sterrett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ernest B. Tremmel-husband-same as 2d</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> <u>977X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Stab wound in left chest(Heart)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Reported to have been under psychiatric treatment</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted wound in left chest</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> p.m. <u>9/23/1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Bethesda, Maryland</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>SEP 25 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHART
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. SIGNATURE OF MEDICAL EXAMINER		10. SIGNATURE OF CORONER		11. SIGNATURE OF JURY		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERGY		16. SIGNATURE OF OTHERS	
17. SIGNATURE OF MEDICAL EXAMINER		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF WITNESSES	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF CLERGY		24. SIGNATURE OF OTHERS	
25. SIGNATURE OF MEDICAL EXAMINER		26. SIGNATURE OF CORONER		27. SIGNATURE OF JURY		28. SIGNATURE OF WITNESSES	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF NEXT OF KIN		31. SIGNATURE OF CLERGY		32. SIGNATURE OF OTHERS	
33. SIGNATURE OF MEDICAL EXAMINER		34. SIGNATURE OF CORONER		35. SIGNATURE OF JURY		36. SIGNATURE OF WITNESSES	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF NEXT OF KIN		39. SIGNATURE OF CLERGY		40. SIGNATURE OF OTHERS	
41. SIGNATURE OF MEDICAL EXAMINER		42. SIGNATURE OF CORONER		43. SIGNATURE OF JURY		44. SIGNATURE OF WITNESSES	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF NEXT OF KIN		47. SIGNATURE OF CLERGY		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF MEDICAL EXAMINER		50. SIGNATURE OF CORONER		51. SIGNATURE OF JURY		52. SIGNATURE OF WITNESSES	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF NEXT OF KIN		55. SIGNATURE OF CLERGY		56. SIGNATURE OF OTHERS	
57. SIGNATURE OF MEDICAL EXAMINER		58. SIGNATURE OF CORONER		59. SIGNATURE OF JURY		60. SIGNATURE OF WITNESSES	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF CLERGY		64. SIGNATURE OF OTHERS	
65. SIGNATURE OF MEDICAL EXAMINER		66. SIGNATURE OF CORONER		67. SIGNATURE OF JURY		68. SIGNATURE OF WITNESSES	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF NEXT OF KIN		71. SIGNATURE OF CLERGY		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF MEDICAL EXAMINER		74. SIGNATURE OF CORONER		75. SIGNATURE OF JURY		76. SIGNATURE OF WITNESSES	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF NEXT OF KIN		79. SIGNATURE OF CLERGY		80. SIGNATURE OF OTHERS	
81. SIGNATURE OF MEDICAL EXAMINER		82. SIGNATURE OF CORONER		83. SIGNATURE OF JURY		84. SIGNATURE OF WITNESSES	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF CLERGY		88. SIGNATURE OF OTHERS	
89. SIGNATURE OF MEDICAL EXAMINER		90. SIGNATURE OF CORONER		91. SIGNATURE OF JURY		92. SIGNATURE OF WITNESSES	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF NEXT OF KIN		95. SIGNATURE OF CLERGY		96. SIGNATURE OF OTHERS	
97. SIGNATURE OF MEDICAL EXAMINER		98. SIGNATURE OF CORONER		99. SIGNATURE OF JURY		100. SIGNATURE OF WITNESSES	

CERTIFICATE OF DEATH

Reg. Dist. No.

10419

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>			
c. LENGTH OF STAY IN 1b <u>2 weeks</u>				d. STREET ADDRESS <u>7107 Cedar Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7107 Cedar Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Judith ANN</u> Middle <u>ROSE</u> Last <u>VERE</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25, 1958</u>	
9. AGE (In years lost birthday) yrs. <u>2</u>		10. AGE (In years lost birthday) yrs. <u>23</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>23</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN W. VERE</u>				14. MOTHER'S MAIDEN NAME <u>GERTRUDE A. THOMPSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mr. John W. Vere, 7107 Cedar Ave.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>focal interstitial pneumonitis, early</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO <u>Pneumonia</u> (*) <u>Pneumonia</u> c) <u>Capillary hemangioma of skin and liver</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Possible Septicemia (pending blood culture)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>contusion</u>			
20c. TIME OF INJURY Hour <u></u> o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>birth</u> , 19 <u></u> , to <u>Sept 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 16</u> , 19 <u>58</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9927 Pershing Dr., Silver Spring, Md.</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>Winston E. Cochran</u>				M.D. <u>9927 Pershing Dr., Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>WINSTON E. COCHRAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>9/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziaka</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE DEPARTMENT OF HEALTH - BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10420

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KENSINGTON			
4. NAME OF DECEASED (Type or print) First EARL Middle A Last WAGNER				4. DATE OF DEATH Month Sept Day 15 Year 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/14	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months 6 Days 10	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10b. KIND OF BUSINESS OR INDUSTRY Plumbing Cont		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME WA. WAGNER			14. MOTHER'S MAIDEN NAME LAVINIA DAYMude				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. Yes-Unknown		17. INFORMANT Mother Address Mrs. William A Wagner-same as 2D		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE FROM ESOPHAGEAL VARICES 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PORTAL CIRRHOSIS DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 day YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SQUAMOUS CELL CARCINOMA PHARYNX WITH METASTASES							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 , to Sept 15, 1958 , that I last saw the deceased alive on Sept 14, 1958 , and that death occurred at 6:03 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8025 ABERDEEN RD DATE SIGNED 9/15/58							
ACTUAL SIGNATURE DeWitt E. DeLawter			M.D. Bethesda 14, MARYLAND				
PHYSICIAN'S NAME (Type) DeWITT E. DELAWTER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR SEP 16 '58		24b. REGISTRAR'S SIGNATURE C. L. S. K. K.	

10434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5004 DelRay Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>M. A.</u> Last <u>WAHL</u>				4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14, 1871</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>? Kroeger</u>				14. MOTHER'S MAIDEN NAME <u>? Filter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John A. Wah.-son-4826 McArthur Blvd. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive heart failure</u> (c) <u>arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u> <u>3 mos.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>49</u> , to <u>13 Sept.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>13 Sept.</u> , 19 <u>58</u> , and that death occurred at <u>2 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7659 Old Georgetown Rd. Beth</u> <u>9/13/58</u>							
ACTUAL SIGNATURE <u>John M. Wyman</u>				M.D. <u>7659 Old Georgetown Rd. Bethesda, Md</u>			
PHYSICIAN'S NAME (Type) <u>John M. Wyman</u>				M.D. <u>7659 Old Georgetown Rd. Bethesda, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kras</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 FilmG234 10-2-58 et
10435
CERTIFICATE OF DEATH

10422

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONT GOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>105 Hutton Street</u>		d. STREET ADDRESS <u>105 Hutton St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Ward</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-74</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL RYAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY O'CONNELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Monica Ward 5030-1st St. N.W. Wash. D.C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>331X</u> DUE TO <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension, Arteriosclerosis</u> DUE TO (c) <u>Hypertension, Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 12, 1958</u> , to <u>9/24, 1958</u> , that I last saw the deceased alive on <u>Sept 21, 1958</u> , and that death occurred at <u>10:00M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Luciano I. Leal</u> M.D.		ADDRESS (Street, city or town, state) <u>108 N. Frederick Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Luciano I. Leal</u>		DATE SIGNED <u>Gaithersburg Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>9-24-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Melrose, Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>Wash. D. C.</u>		24a. REC'D BY REGISTRAR <u>SEP 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

10436

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Loudon			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Shamrock Warner				4. DATE OF DEATH Month Day Year September 23, 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1880		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Masonry		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Warren				14. MOTHER'S MAIDEN NAME Katherine Jordan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of Prostrate 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last, (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Arteriosclerotic heart disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 2, 1958 , to September 23, 1958 , that I last saw the deceased alive on September 23, 1958 , and that death occurred at 6:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. R. Rose (R/S)		M.D. J. R. Rose, M. D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 9-23-58	
PHYSICIAN'S NAME (Type) J. R. Rose, M. D.		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/58		22c. NAME OF CEMETERY OR CREMATORY Negro Cemetery		22d. LOCATION (City, town, or county) (State) Middleburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Humphrey				ADDRESS 7552 Wisconsin Ave Bethesda		24a. REC'D BY REGISTRAR SEP 25 58	
						24b. REGISTRAR'S SIGNATURE Arthur S. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10437

CERTIFICATE OF DEATH

Reg. Dist. No. 10424

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9811 Culver Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DOROTHY Middle MAY Last WATT				4. DATE OF DEATH Month Sept Day 8 Year 19 58			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/1914	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 4 Days 29		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY Safeway Store		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Nicholas Siegel				14. MOTHER'S MAIDEN NAME Margaret Watson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 165-20-7834			
17. INFORMANT Wm. N. Watt-Husband-item #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic HEART Disease 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from Nov. , 19 57 , to Sept 8 , 19 58 , that I last saw the deceased alive on August 7 , 19 58 , and that death occurred at 9:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8025 ABERDEEN Rd. Bethesda Md DATE SIGNED 9/8/58							
ACTUAL SIGNATURE De Witt E. DeLauter				M.D. 8025 ABERDEEN Rd. Bethesda Md			
PHYSICIAN'S NAME (Type) DEWITT E. DELAUTER				8025 Aberdeen Rd. Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF WITNESS		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF REGISTRAR	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF NEXT OF KIN		28. SIGNATURE OF WITNESS		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF REGISTRAR	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF WITNESS		34. SIGNATURE OF PHYSICIAN		35. SIGNATURE OF REGISTRAR	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF NEXT OF KIN		38. SIGNATURE OF WITNESS		39. SIGNATURE OF PHYSICIAN		40. SIGNATURE OF REGISTRAR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF WITNESS		44. SIGNATURE OF PHYSICIAN		45. SIGNATURE OF REGISTRAR	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF WITNESS		49. SIGNATURE OF PHYSICIAN		50. SIGNATURE OF REGISTRAR	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF NEXT OF KIN		53. SIGNATURE OF WITNESS		54. SIGNATURE OF PHYSICIAN		55. SIGNATURE OF REGISTRAR	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF NEXT OF KIN		58. SIGNATURE OF WITNESS		59. SIGNATURE OF PHYSICIAN		60. SIGNATURE OF REGISTRAR	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF WITNESS		64. SIGNATURE OF PHYSICIAN		65. SIGNATURE OF REGISTRAR	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF NEXT OF KIN		68. SIGNATURE OF WITNESS		69. SIGNATURE OF PHYSICIAN		70. SIGNATURE OF REGISTRAR	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF WITNESS		74. SIGNATURE OF PHYSICIAN		75. SIGNATURE OF REGISTRAR	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF WITNESS		79. SIGNATURE OF PHYSICIAN		80. SIGNATURE OF REGISTRAR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF WITNESS		84. SIGNATURE OF PHYSICIAN		85. SIGNATURE OF REGISTRAR	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF NEXT OF KIN		88. SIGNATURE OF WITNESS		89. SIGNATURE OF PHYSICIAN		90. SIGNATURE OF REGISTRAR	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF WITNESS		94. SIGNATURE OF PHYSICIAN		95. SIGNATURE OF REGISTRAR	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF NEXT OF KIN		98. SIGNATURE OF WITNESS		99. SIGNATURE OF PHYSICIAN		100. SIGNATURE OF REGISTRAR	

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF REGISTERING THE DEATH OF A PERSON WHOSE DEATH HAS BEEN REPORTED TO THE HEALTH DEPARTMENT OF THE STATE OF MARYLAND. IT IS NOT VALID FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS PROPERLY FILLED OUT AND THAT THE INFORMATION IS CORRECT. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE CAUSE OF DEATH. IT IS THE DUTY OF THE NEXT OF KIN TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE MANNER OF DEATH. IT IS THE DUTY OF THE WITNESS TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE PLACE OF DEATH. IT IS THE DUTY OF THE DECEASED TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE DATE OF BIRTH. IT IS THE DUTY OF THE REGISTRAR TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE DATE OF DEATH. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE CAUSE OF DEATH. IT IS THE DUTY OF THE NEXT OF KIN TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE MANNER OF DEATH. IT IS THE DUTY OF THE WITNESS TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE PLACE OF DEATH. IT IS THE DUTY OF THE DECEASED TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE DATE OF BIRTH. IT IS THE DUTY OF THE REGISTRAR TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE DATE OF DEATH.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10438

CERTIFICATE OF DEATH

10425
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN 1b <u>12 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Germantown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>1 Schniders Traylor Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>Faron</u> Last <u>WHITE</u>		4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>19 58</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 September 1958</u>	9. AGE (In years last birthday) yrs. <u>15</u>	IF UNDER 1 YEAR Months <u>15</u>	IF UNDER 24 HRS. Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Lee Olin WHITE</u>				14. MOTHER'S MAIDEN NAME <u>Ida Ann DUVALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(Father) Lee Olin WHITE (Same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>768.5</u> IMMEDIATE CAUSE (a) <u>Bacteremia, Staphylococcus aureus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Prematurity</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>15 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>6 September</u> , 19 <u>58</u> , to <u>17 September</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>17 September</u> , 19 <u>58</u> , and that death occurred at <u>1:40 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>David Harris</u> M.D. <u>U. S. Naval Hospital, Bethesda, Md</u>				DATE SIGNED <u>9-17-58</u>			
PHYSICIAN'S NAME (Type) <u>David Harris, LT, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-19-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Gaithersburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Pumphrey</u>				ADDRESS <u>7557 Wisconsin Ave. Bethesda, Md</u>		24a. REC'D BY REGISTRAR <u>SEP 19 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>				DATE _____			

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REP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10435 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10426
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	c. LENGTH OF STAY in 1b 10 Year	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6816 Brookville Rd.		d. STREET ADDRESS 6816 Brookville Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Harry Franklin White		4. DATE OF DEATH Month Sept. Day 15 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/24/1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Gov. employee	11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Franklin White		14. MOTHER'S MAIDEN NAME Martha Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Bernard H. White, / Radnor, Penn.		Address 582 Cricket	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 17	
22c. NAME OF CEMETERY OR CREMATORY Laytonsville		22d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Barber		24a. REC'D BY REGISTRAR DATE SEP 18 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Film G-234 10/10/58 cac.

CERTIFICATE OF DEATH

10296

10427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 16 hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital			d. STREET ADDRESS 1401 Sheridan St. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Margaret Middle Rachel Last White			4. DATE OF DEATH Month Sept Day 10 Year 1958		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-1918	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) District of Columbia	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Charles G. Harman			14. MOTHER'S MAIDEN NAME Mary F. Fluery		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive HEART Failure DUE TO (b) Pneumonia, Left & Right Lung DUE TO (c) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 28 hours 28 hours 20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, Pernicious type. Diabetes Mellitus					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 493X			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Oct , 19 58 , to Sept 10 , 19 58 , that I last saw the deceased alive on Sept 10 , 19 58 , and that death occurred at 8:05 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE George B. Patrick, Jr.		ADDRESS (Street, city or town, state) 8700 Colesville Rd.		DATE SIGNED 9-10-58	
PHYSICIAN'S NAME (Type) George B. Patrick, Jr. M.D.		Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 9-13-1958	22c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Don		ADDRESS 4411 Mass Ave Washington, DC		24a. REC'D BY REGISTRAR DATE SEP 15 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

STATE OF MARYLAND

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan. Some visible text includes "STATE OF MARYLAND" and "CERTIFICATE OF DEATH".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10440

CERTIFICATE OF DEATH

Reg. Dist. No. 10428

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>15 mins</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>9807 RIVER Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fredrick Whitmore</u>		4. DATE OF DEATH Month Day Year <u>9 26 1958</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>W.</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 17, 1880</u>	
9. AGE (In years last birthday) yrs. <u>78</u>		IF UNDER 1 YEAR: Months Days Hours Min. <u>34</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Express Del. man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Express Co</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Whitmore</u>		14. MOTHER'S MAIDEN NAME <u>Mary Carr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Niece Mrs Ruth Leach Alexandria, Va.</u>		Address <u>211 E. Dupont</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforation, Metastatic carcinoma to colon</u> DUE TO (c) <u>Carcinoma of Stomach.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>24 Sept</u> , 19 <u>58</u> , to <u>26 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>26 Sept</u> , 19 <u>58</u> , and that death occurred at <u>4:30 p.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>9902 A Counselman Rd</u> <u>9-26-58</u>			
ACTUAL SIGNATURE <u>J. S. Counselman, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept 29, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ziskel Funeral Home</u> ADDRESS <u>510 E. St</u>		24a. REC'D BY REGISTRAR <u>SEP 30 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>William J. Gable</u>		24c. REGISTRAR'S SIGNATURE <u>William J. Gable</u>	

No 268 Mahon J. Gable Washington D.C.

10441

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
f. STREET ADDRESS <u>2915 Woodstock Ave</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Newborn Infant</u> Middle <u>Girl</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 11, 1958</u>	
9. AGE (In years last birthday) <u>2 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer M. Williams</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Maddox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Elmer M. Williams</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>760.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anoxia</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) (County) (State) <u>—</u>				20g. (City or town) (County) (State) <u>—</u>			
21. I certify that I attended the deceased from <u>9/11</u> , 19 <u>58</u> , to <u>9/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/11</u> , 19 <u>58</u> , and that death occurred at <u>9:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>9/12/58</u>							
ACTUAL SIGNATURE <u>William J. Evans</u> M.D.				DATE SIGNED <u>9/12/58</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM J. EVANS</u>				DATE SIGNED <u>9/12/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Knecht</u>				DATE <u>SEP 15 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10442

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
c. LENGTH OF STAY IN 1b 6 days		d. STREET ADDRESS 6622 Willston Place	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Jeffrey Last WINSTEAD		4. DATE OF DEATH Month September Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Sept. 1958
9. AGE (In years last birthday) yrs. 6		IF UNDER 1 YEAR Months 6 Days 6 Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Finley Gilbert WINSTEAD		14. MOTHER'S MAIDEN NAME Joan Marie KLEIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT (Father) Finley G. Winstead (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) meningitis DUE TO 751X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) meningo myelocel DUE TO spina bifida (c) spina bifida		INTERVAL BETWEEN ONSET AND DEATH 1 day 6 6	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Sept. 19 58 , to 7 Sept. 19 58 , that I last saw the deceased alive on 7 Sept. 19 58 , and that death occurred at 4:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard A. Pearson M.D.		ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-8-58	
PHYSICIAN'S NAME (Type) Howard A. Pearson, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Walter H. Morris Arlington Funeral Home 3901 N. Fairfax Dr.		24a. REC'D BY REGISTRAR SEP 9 '58	
24b. REGISTRAR'S SIGNATURE Charles S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051254XV6

CERTIFICATE OF DEATH

JOHN SMITH

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10443 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10431

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. STREET ADDRESS <u>7703 Westfield Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Townley R Wolfe IV</u>		4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-'44</u>
9. AGE (In years last birthday) <u>14</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u></u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
13. FATHER'S NAME <u>Townley R. Wolfe III</u>		14. MOTHER'S MAIDEN NAME <u>Doris Knoche</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Father</u>		Address <u>Townley R Wolfe III</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE INTRACEREBRAL HEMORRHAGES</u> 813X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MULTIPLE CEREBRAL CONTUSIONS AND LACERATIONS</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>31 hours</u> <u>31 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Riding bicycle & struck by auto</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:24</u> a.m. <u>9/23</u> 19 <u>58</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	20f. (City or town) <u>Bethesda</u> (County) <u>montg</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/29/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u> ADDRESS <u>Ellsworth Armacost-4600 Liberty Hgts. Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 30 58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
100-1
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH

FILE NO. 100-1

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SIGNATURE OF EXAMINER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF WITNESS

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SIGNATURE OF EXAMINER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF WITNESS

AGE

SEX

10444

CERTIFICATE OF DEATH

Reg. Dist. No. 10432

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6809 Delaware St.				d. STREET ADDRESS 6809 Delaware Street			
3. NAME OF DECEASED (Type or print) BARBARA HILMAN WURDEMAN				4. DATE OF DEATH Month Sept. Day 1 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/19/70	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 5 Days 12 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? US.	
13. FATHER'S NAME Daniel Artes				14. MOTHER'S MAIDEN NAME Sophia Keremlin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Karl Plitt-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial decomp 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocardial decomp. DUE TO (c) Arteriosclerosis, general, severe						INTERVAL BETWEEN ONSET AND DEATH 15 min. 6 months 4 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma, chronic						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) 	(County) 	(State) 		
21. I certify that I attended the deceased from March, 1957 , to Sept 1, 1958 , that I last saw the deceased alive on Aug 15, 1958 , and that death occurred at 8:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St. Wash 15 D.C. DATE SIGNED 9-1-58							
ACTUAL SIGNATURE Stewart Clapp		M.D. 3921 Ingomar St. Wash 15 D.C.					
PHYSICIAN'S NAME (Type) Stewart Clapp		Wash 15 D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/3/58	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill	22d. LOCATION (City, town, or county) (State) Washington, D.C.				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR SEP 2 58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

Coroner Notified and released case

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be reformed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10445

CERTIFICATE OF DEATH

10433

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
c. LENGTH OF STAY IN 1b <u>36 days</u>				d. STREET ADDRESS <u>147101 Essex Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Young</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/15/83</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Salmon, Mass.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Thomas Young</u>				14. MOTHER'S MAIDEN NAME <u>Martha Monroe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-34-6325</u>		17. INFORMANT <u>Anna Young - Above</u> Address <u>-----</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rt. Hemiplegia, severe, with aphasia</u> DUE TO <u>334x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general, severe</u> DUE TO <u>5 yrs +</u> (c) <u>-----</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left hemiplegia, severe</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>-----</u> p. m. <u>-----</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , to <u>Sept 6, 1958</u> , that I last saw the deceased alive on <u>Sept 5, 1958</u> , and that death occurred at <u>7:20 a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stewart Clapp</u>				DATE SIGNED <u>9.6.58</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				ADDRESS <u>3921 Ingomar St. N.W. Wash 15 D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 9 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Christina L. Haud</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		NEW YORK		NEW YORK		UNITED STATES	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1234 MAIN ST.		LABORER		HEART DISEASE		NATURAL		JAN 15 1925		HOSPITAL		BOSTON		MASS.	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS MARRIAGES	
JAMES H. HARRIS		MARY J. HARRIS		ELIZABETH HARRIS		JOHN HARRIS		HIGH SCHOOL		METHODIST		MARRIED		ONE	
DATE OF INTERVIEW		BY WHOM INTERVIEWED		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	
JAN 15 1925		DR. J. H. HARRIS		JAMES H. HARRIS		MARY J. HARRIS		DR. J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BOSTON, MASS.

WITNESSED MY HAND AND SEAL OF OFFICE, THIS 15TH DAY OF JANUARY, 1925.

JOHN J. HARRIS, REGISTRAR OF DEATHS, BOSTON, MASS.